Patient and Staff Experiences of Coercive Care

A thesis submitted in partial fulfilment of the requirements for the Doctorate in Clinical Psychology.

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List of Abbreviations

AES	Admission Experience Survey
AOT	Assertive Outreach Team
AMHP	Approved Mental Health Practitioner
BPRS	Brief Psychiatric Rating Scale
CQC	Care Quality Commission
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CTO	Community Treatment Order
GAF	Global Assessment of Functioning
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
OT	Occupational Therapist
PCS	Perceived Coercion Scale
RC	Responsible Clinician
VAS	Visual Analogue Scale

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Declaration and Authorship

This thesis was carried out under the supervision of Dr Adrian Neal, Dr Sally Bradley and Dr Alan Meaden, all of whom were involved in the initial formulation of ideas, development of the research design and drafting of papers. Dr Adrian Neal also offered a co-ordinating role, Dr Sally Bradley facilitated the recruitment of participants and Dr Alan Meaden provided supervisory guidance during the process of data analysis. In addition, Dr Helen Liebling-Kalifani also offered general feedback at the data analysis stage. Apart from these collaborations this thesis is all my own work. These chapters have been prepared for submission to journals and authorship of any papers derived from this research will be shared with the supervision team as appropriate. The thesis has not been, and will not be, submitted for a degree at any other university. The empirical paper has also been written up as a research poster which will be presented at future conferences.

Summary

It is generally accepted that the use of compulsory powers in the treatment of mental health difficulties may be required to prevent harm to self or others. Exploring the experiences of patients and staff in relation to the use of coercive measures can offer a meaningful insight into how clinical settings might best meet the needs of their clients.

Chapter 1 consists of a systematic review of the literature exploring inpatient experiences of coercion by asking 'what are patients' emotional experiences of psychiatric inpatient care?' and 'what can be done to help minimise the negative impact of patients' experiences of coercion?' Negative experiences were found to impact upon prognosis, engagement and later attitudes to accessing care; core emotions experienced included fear, anger and sadness. Suggestions for ways of minimising the negative impact of coercion have been discussed in depth.

Chapter two presents an empirical study conducted in an Assertive Outreach Team (AOT) which explored staff experiences of working with Community Treatment Orders (CTOs). Eight multidisciplinary team members participated in interviews. Following the use of Interpretative Phenomenological Analysis, three superordinate themes emerged from the data. The findings emphasise the individual way in which clients were perceived to respond to the implementation of the CTO and explore the tension that staff experience between the use of engagement and coercion. Clinical implications were discussed as well as suggestions for further research.

The final paper offers a reflective account of the research process. It is structured around the three superordinate themes which emerged from the empirical data and considers the way in which the researcher's own experiences were closely related to issues arising from the research. Methodological limitations and ethical issues are discussed as well as an exploration of the way that personal style has influenced the process and facilitated future self-development.

Chapter One: Literature Review

Patients' experiences of coercive psychiatric treatment: a systematic review of the literature

This paper has been prepared for submission to the Journal Clinical Psychology Review.

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1.1 Abstract

It is generally accepted that involuntary psychiatric treatment may be required to prevent harm to self or others. A wide range of involuntary treatment measures are considered coercive, including restraint, seclusion and forced pharmacological treatment. Exploring patients' emotional experiences of coercion is important as it can offer a meaningful insight into how clinical settings can be shaped to best meet the needs of this client group.

This systematic review of the literature explored inpatient experiences of coercion and asked 'what are patients' emotional experiences of psychiatric inpatient care?' and 'what can be done to help minimise the negative impact of patients' experiences of coercion?'

Key emotions relating to the experiences of coercion included fear, anger and sadness. Negative experiences were also found to impact upon prognosis, engagement and later attitudes to accessing care. Many patients felt disrespected and undervalued when under coercive powers although some shared experiences of good care they had received. Several ways of minimising the negative impact of coercion have been discussed, including routinely seeking patients' views and monitoring the use of 'unregulated coercion'. Further suggestions include enhancing the quality of the hospital environment by attending to basic needs such as food, privacy, occupation and emotional support. Clinical implications and ideas for further research are discussed.

1.2 Introduction

It is generally accepted that involuntary treatment is appropriate for some people with mental health difficulties at certain times. Such treatment is predominantly used with the aim of reducing harm to self or others and can consist of a range of coercive measures. These include physical restraint, seclusion, forced pharmacological treatment and restrictions upon life in the community. This specific form of psychiatric care offers clinicians significant power over individuals' civil liberties, which, despite being based upon the patients' best interests, (World Psychiatric Association, 2005) some claim can be used inappropriately.

In spite of such practices being widespread, the effect of coercion upon engagement and collaboration is unclear. Those in favour of a more paternalistic and often coercive form of mental health provision criticise those against coercion for not protecting vulnerable people when they are most in need of care. A conflict between the civil liberties of an individual and the need to protect that individual arises, as well as a conflict within healthcare whereby "the paternalistic view in which health status is determined 'objectively' by a doctor conflicts with an empathic assessment based on collaboration between doctor and patient" (Stastny, 2000, p.22). There is a wide range of literature exploring the concept of patient satisfaction but less focussing on the use of coercion. The concept of coercion refers to the practice of overruling the volition of an individual by using pressure, force or intimidation to obtain compliance. It is therefore subjective in nature, as it depends upon the individuals own definition of what comprises 'pressure'. This creates a complex relationship between coercion and compulsion because whilst all enforced treatment has the potential to be experienced as coercive, not every client may experience it as

such. Defining 'coercion' therefore is difficult as it transcends obviously coercive techniques such as physical restraint and incorporates other, less clear elements such as the threat of sanctions or restriction of movement. In contrast involuntary treatment is not thought to have severe adverse side effects for most of those who experience it (Owen, David and Hayward et al, 2009; Katsakou, Bowers, Amos et al, 2010) with many clients retrospectively agreeing with their care (Greenberg, Moore-Duncan and Herron, 1996). Despite this, some patients experience a loss of autonomy and a feeling that they are disrespected; 'good care' is crucial to militate against this (Andreasson and Skarsatter, 2012) as well as a better understanding of the variation in patients' experiences.

1.3 Rationale for Literature Review

Patients' emotional experiences of coercion in psychiatric care are important; they can be linked to a range of experiences (Lidz et al, 1998; Haglund, Von Knorring and Von Essen, 2003) and are not restricted to involuntary legal status (Hoge et al., 1997; Kjellin et al, 2004). Such experiences offer a meaningful insight into how clinical settings can be shaped to best meet the needs of this client group. Whilst a review has been conducted upon patients' experiences of involuntary treatment, it focuses on a small sample of qualitative studies and asks questions relating to the type of experiences reported by clients (Katsakou and Priebe, 2007). There are, however, no known reviews on patients' experiences of coercion. Inpatient coercion is often considered controversial (Poulsen, 1999; Lucksted and Courtsey, 1995; Hughes, Hayward and Finlay, 2009). This current review will investigate coercion

in an inpatient setting. Research published since the 1983 Mental Health Act will form the basis of this review.

1.4 Literature Review Aims

The present review systematically explores qualitative and quantitative research on patients' experiences of coercion in inpatient psychiatric care. This will include both voluntary and involuntary commitment and detention, as well as coercive practices such as forced medication, seclusion and restraint. The following questions will be asked of the literature:

1) What are patients' emotional experiences of psychiatric inpatient care?
2) What can be done to help minimise the negative impact of patients' experiences of coercion while in involuntary care.

1.5 Systematic Search Strategy

This process is outlined in Table 1.1. Literature searches were performed between January and April 2012. The following databases were used in the review: Medline, Pilots, Psyarticles, Psychinfo, ASSIA (Applied Social Sciences Index and Abstracts), Social Services Abstracts and Sociological Abstracts. Only peer reviewed published journal articles were included. Papers were identified using the following search terms:

Perspective/ view/ attitude/ experience/ narrative/ perce*/ evaluation AND

Client/ patient/ service user/ men/ women/ user/ consumer AND

Involuntary/ compulsory/ coerc*/ enforce*/ force* AND

Treat*/ care/ detention/ commit*/ admission/ hospital*/ psychiat*

1.6 Inclusion and Exclusion Criteria

Articles were examined for relevance; unrelated and duplicate papers were removed. All relevant empirical research conducted in a psychiatric inpatient setting and published since 1983 was included. To enable homogeneity, articles focussing on areas such as substance misuse, eating disorders and the forensic population were excluded. Papers about research conducted in community settings were also excluded, as were those exploring the experiences of children, professionals and family members or carers.

Table 1.1: Literature Review Systematic Search Strategy

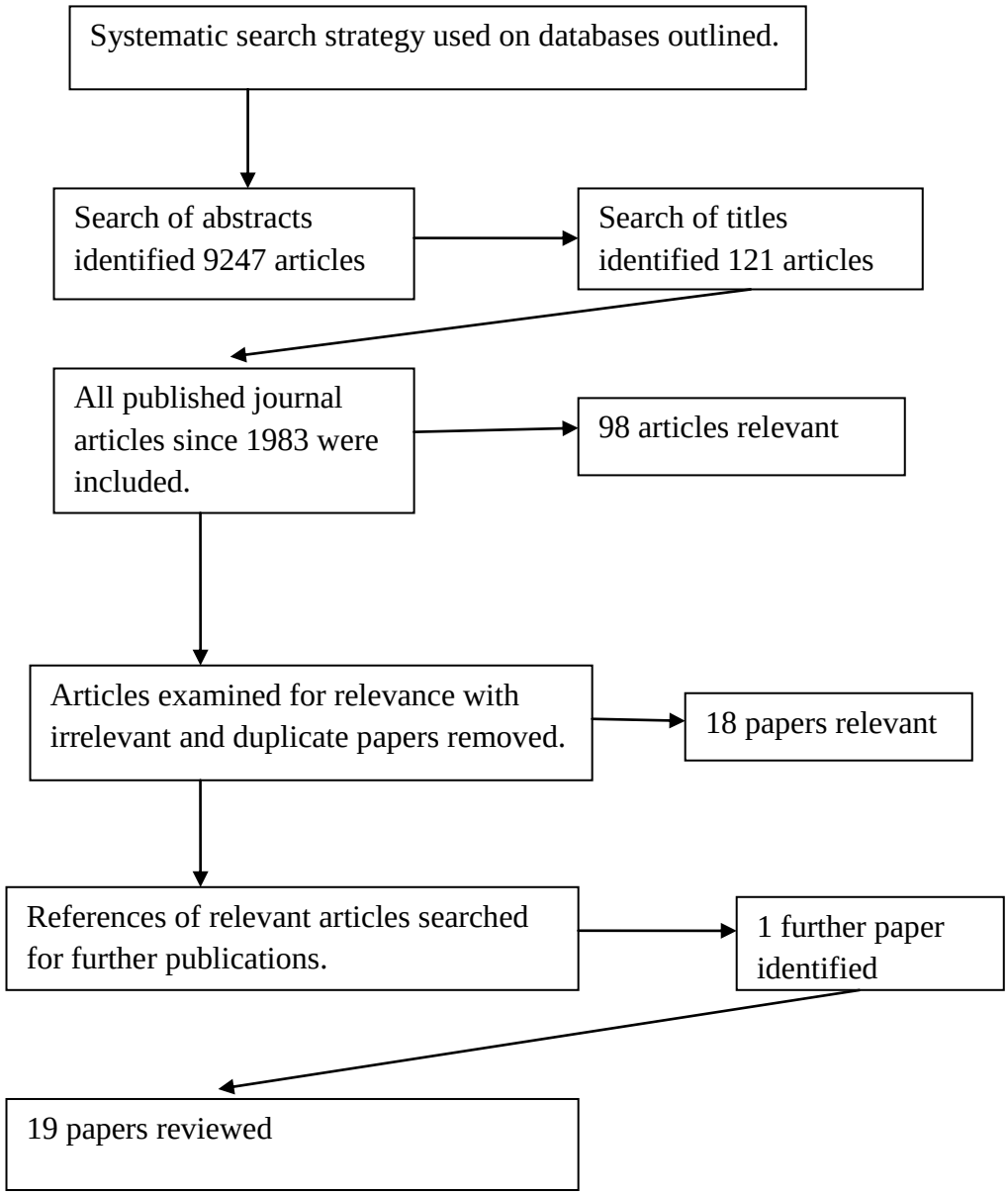

Table 1.2 summarises the journal articles incorporated into the current literature review and presents their key findings. They are listed alphabetically according to their author.

Table 1.2: Table of Studies

Study	Setting	Aims	Participants	Design & Method	Major findings
A survey of involuntary patients' attitudes to their commitment (Bradford, McCann and Herskey, 1986)	3 admission units and a behaviour modification unit Ontario, US	To elicit views on the attitudes of involuntary patients towards their commitment.	N=57 Age: 17-61 yrs. Main diagnoses: Schizophrenia, manic depressive illness and other severe depressive disorders.	Developed own survey based upon a previously established questionnaire; interviews administered while patients were in hospital.	Age, sex and marital status did not significantly affect the attitude towards treatment. <u>Positive attitudes:</u> 81% reported having been helped, 54% would return again if needed and 35% reported positive feelings concerning their treatment. 19% believed basic needs well provided for. 14% enjoyed socializing and friendly atmosphere. <u>Negative attitudes:</u> 61% felt involuntary admission inappropriate. 35% felt it to have been a negative experience. 23% liked nothing about their stay, 42% indicated restricted freedom was primary complaint. 14% were bored and 11% found proximity of other patients hard to cope with. <u>Legal Status</u>: 46% reported having been give an option to come. 44% were aware of their legal rights. 40% felt they were previously a danger to self.
Patient perceptions of coercion in mental hospital admission (Hiday, Swartz, Swanson and Wagner, 1997)	Admission unit of a state mental hospital and the psychiatric units of three general hospitals; they had been court-ordered to outpatient	To explore patients' perceptions of coercion.	N=331. Age: 20-70 years Psychiatric patients who had been involuntarily admitted because of severe mental disorder.	Baseline data from another study was used. Sample subjects were given an extensive interview in the hospital (including diagnostic assessment, measures of health and mental health	Three sets of predictor variables were examined in three consecutive models for each dependent variable. Variables were perceived coercion, perceived negative pressures and perceived procedural inequity. *Coercion*: Based on the 3 effect models, being male, African-American, and married/ cohabiting was associated with higher scores. <u>Negative Pressures</u>: Education is significantly associated with higher levels of negative pressures; African-American

	commitment following hospital discharge. North Carolina, USA.		Diagnosis of schizophrenia, affective disorder or other psychotic disorder.	functioning and 15 true/false items of the MacArthur Interpersonal Relations Scale).	females and white males are more likely to experience negative pressures, whereas African-American males are unexpectedly low in reporting negative pressures.
Patients' perceptions of the impact of involuntary inpatient care on self, relationships and recovery (Hughes, Hayward and Finlay, 2009)	Psychiatric patients in the UK (inpatient and outpatient settings).	To provide a detailed consumer perspective of involuntary inpatient care and how this is perceived to have impacted upon the self, relationships and recovery.	N=12 Age: 19-62yrs Diagnoses: bipolar affective disorder, borderline personality disorder, schizophrenia and depression.	60-90 minute semi-structured interviews divided into 4 main parts: demographic information and history of contact with mental health services, experiences of involuntary hospital admission, experiences of being an involuntary inpatient and related experiences after discharge. Interviews transcribed and analysed using thematic analysis.	Superordinate themes: Process of being involuntarily admitted to hospital During involuntary hospitalisation After discharge Paper outlines subthemes of first superordinate theme: <u>Self</u> (half said they had retained their sense of self whilst in hospital; of the other half extreme negative experiences were reported including being disrespected and undervalued) <u>Experience of relationship and interactions</u> (positive and negative with 1/3 reporting feeling cared for by staff) <u>Medication</u> (majority had negative experiences: of side effects and of it being administered)
Patients' experiences of involuntary psychiatric care:	Two hospital clinics and local mental healthcare	To illuminate the experience of being subjected to involuntary	5 psychiatric patients who had been involuntarily hospitalised within	Narrative interviews lasting 10 - 60 minutes were conducted in participants' homes	<u>Stage 2 analysis:</u> Being restricted in autonomy Being violated by intrusion on physical integrity and

good opportunities and great losses (Johansson and Lundman, 2002)	centres. Western Sweden (May-August 1998)	psychiatric care.	the last 2 years. 3 women and 2 men. Age range: 27-49 years old.	or at a clinic. Interviews were transcribed and analysed using a phenomenological hermeneutic method involving 3 stages: 'naive reading', establishment of patterns and interpretation as a whole.	human value Being outside and not seen or heard Being respected as an individual Being protected for and cared for <u>Stage 3 analysis:</u> Freedom, control and protest Information Violation of integrity, violence and inhuman treatment
Clients' perceptions of involuntary hospitalization. (Joseph-Kinzelman, Taynor, Rubin, Ossa and Risner, 1994)	Patients from a community mental health centre across rural Midwest three county catchment area in Ohio, US. (September 1991 – May 1992)	To understand more about the experiences of patients who have been involuntarily admitted to psychiatric care.	Participants who had been involuntarily admitted to a state psychiatric hospital. N=15	Exploratory study; part of a larger study. Open-ended interview schedule was administered lasting 1-3 hours. Interview focussed upon 7 chronological events in the involuntary hospitalization experience.	<u>Being taken to hospital for emergency admission</u>- intense discomfort about previous life; feelings of panic, fear and failure about admission. <u>Going through the admission process</u>- fear, confusion and wanting emotional support. <u>Participation in court proceedings</u>- feelings of being trapped, angry and sad. <u>Experiencing involuntary hospitalization</u>- emotionally painful and demanding experience (anger, fear, sadness and feeling trapped). <u>Leaving the hospital</u>- key was making life plans. Staff were helpful. <u>Returning to the community</u>- action oriented, hopeful and demanding time. <u>Living in the community.</u>

Involuntary psychiatric treatment: A range of patients' attitudes (Kaltiala-Heino, 2010)	Clinic of Tampere, University Hospital, Tampere (Finland) Conducted over three separate periods between 1990 and 1992	Explore opinions of patients with psychosis regarding involuntary psychiatric inpatient treatment.	N=100 Age: 15-64yrs. Psychiatric inpatients with psychosis. (52% female. 32% were married 53% lived with family.) 55% committed; 45% voluntarily admitted.	Survey. Two structured interviews, the first after a 2 week treatment and the second approximately 6 months after discharge. Questions were based on attitude to involuntary treatment and experiences of inpatient care. Demographic and clinical information obtained from Global Assessment of Functioning (GAF) Brief Psychiatric Rating Scale m(BPRS) measures as well as medical notes.	Results were statistically analysed. 74% thought mental illness could be cured 'in most cases' or 'sometimes'. 63% felt that involuntary treatment is necessary at the first interview; this number rose to 84% at follow-up. 31% felt involuntary treatment was beneficial to others but not to self. 34% felt coercion was used too much in psychiatry. 75% felt physicians should decide on commitment; 40% also felt family should have input. Legal status proved of no importance to attitude toward commitment. Those who had experienced admission as coercive were more negative at both interviews.
Consumer perceptions of pressure and force in psychiatric	Rehabilitation centres, Maryland. (US.) Conducted between April –	Obtain information on mental health consumers' experiences of	N= 105 Users of mental health rehabilitation	61 item survey questionnaire covering 3 areas where pressure and	13% said they'd been pressured or forced to take medication (mostly less than 10 times) in the last year. 33 out of 52 respondents reported that they had been unwillingly admitted between 1-5 times over the course of

treatments (Luckstead and Courtsey, 1995)	July 1991.	and attitudes towards forced psychiatric treatment, with particular focus on the use of pressure and force.	centres.	force occur. Nominal data was analysed using chi squared tests.	their illness; 13 reported more than 5 times. Two most reported emotions were anger (24/48) and fear (17/48). 27/51 reported they now felt their admission was in their best interest. 66-77% of participants felt that force should always or sometimes be used. Women were more likely than men to report that when they had been treated involuntarily they were glad someone looked out for their wellbeing. 'Black respondents' were more likely to report people should not be allowed to refuse treatment than 'white respondents' (52% vs 9%). No correlation between consumer experience and attitude. 30% were afraid of being re-admitted if they didn't comply.
Patient perception of coercion on admission to acute psychiatric services (McKenna, Simpson and Laidlaw, 1999)	Two acute psychiatric inpatient services for the adult population (Auckland, New Zealand).	Exploration of the mediating factors of coercion in the context of acute inpatient services.	N= 138 (80 males; 50 females) 17-64 years old 61% were experiencing a psychotic illness at the time of	MacArthur Admission Experience Survey (AES) was administered. Comparisons between groups were made. 3 variables (axis 1	Strong significant difference in comparing the informal and involuntary sample groups with patient perception of coercion (t= -5.29, p=.000). Females perceived a greater sense of coercion than males. Those who were angry, had a psychotic illness or experienced restraint at admission had a greater sense of coercion than those who were not. Multiple stepwise linear regression found that patient perception of procedural justice accounted for 45.2% of

			admission. Voluntarily admitted N=69 Involuntary admitted N=69	diagnosis, living situation and gender) were controlled for in an analysis of covariance.	variations in scores in predicting patient perception of coercion. 62% was predicted by procedural justice, feeling happy at being admitted to hospital, perception of 'negative pressure', emotional feelings of anger and legal status.
Schizophrenic patients' retrospective attitudes regarding involuntary psychopharmacological treatment and restraint (Naber, Kircher and Hessel, 1996)	Conducted across 2 locked wards at the psychiatric clinic of the university of Munich (Germany).	Examination of retrospective attitudes of patients having experienced involuntary treatment.	N= 40 psychiatric inpatients who had undergone involuntary treatment (restraint or neuroleptic injection). Most had diagnoses of schizophrenia.	Participants were recruited 2-5 days before discharge. Interviews occurred 60-80 days after discharge and comprised of 12 questions including one testing memory.	Coercive measures were most utilised during the first 5 days of admission; 33% had received both restraint and injection. 28 participants were able to completely remember circumstances and time period around the coercive measures and 12 partially. 4 showed 'good', 14 showed 'partial' and 22 showed 'poor' levels of insight'. 23 refused treatment because they viewed it as inadequate, 19 because of previous negative experience, 11 were against physicians and hospitals and 12 reported other reasons (7 of whom attributed it to their delusional state). Most participants attributed their refusal to comply with treatment to previous negative experiences of involuntary treatment and many participants felt that they were not respected. Feelings: powerlessness and fear (32 participants) as well as 'rage' and 'not been respected'. Attitude to involuntary treatment had improved by discharge (48% had positive attitude retrospectively)
Involuntary admission from the patients'	183 bedded psychiatric hospital in	To investigate: peoples' perception of the involuntary	N=81 Involuntary psychiatric inpatients over the	Semi-structured interviews designed to elicit patients' attitudes towards	72% felt their admission was necessary prior to discharge; 77.8% felt their treatment was beneficial to their mental health. There was a strong correlation between insight and whether treatment was perceived necessary [r's=0.67,

perspective (O'Donoghue, Lyne, Hill, Larkin, Feeney and O'Callaghan, 2008)	Dublin (UK).	admission, awareness of legal rights and perception of tribunal, impact of being admitted involuntarily on the relationship with their family, consultant psychiatrist and prospects for future employment.	age of 18 years.	their involuntary admission. Insight was assessed using the 'Scale to Assess Unawareness of Mental Disorder' (SUMD). Hospital documents were accessed for information on the use of restraint and seclusion; other information was gained from medical notes. Statistical analysis was used on the data (t-test, chi squared tests, spearman's test and multi-dimensional Chi-square tests.)	n=80, p<0.001, two tailed]. 2 factors reliably predicted perceived necessity; the level of insight and length of time as an involuntary patient. 86.4% of patients were aware that they were admitted involuntarily under the Mental Health Act. A total of 63% of patients stated their treatment was discussed with them and 76.5% consented to taking medication. 48.1% had their case reviewed by a tribunal; 56.8% disagreed with the findings of their tribunal at discharge. The Involuntary Admission Order was initiated by a family member or partner in 49.4% of cases, 65% of whom were aware of this. For 27.5% it had a negative impact on their relationship and for 15% it had a positive impact.
A plea for respect: involuntarily hospitalized psychiatric patients' narratives about being subjected to coercion	Large university psychiatric clinic (Sweden)	Describe involuntarily hospitalized psychiatric patients' narrated experiences of coercion. Q1 What is	N= 18 involuntarily admitted patients (12 women and 6 men) Age: 19-52 years.	Descriptive-explorative design. Qualitative interpretative content analysis was used to analyse the data.	Coercion was perceived as going to hospital, forced to stay on the ward, not allowed to go home, being converted from voluntary to involuntary care. Other forms included 'mechanical restraints' (E.g. personal restraint by nursing staff, room restraint, close nursing supervision, coerced to take medication, threatened with sanctions, not being listened to/ allowed to decide, 'bad attitude' and disrespect from staff.) Participants experiences of coercion were grouped under

(Olofsson and Jacobsson 2001)		coercion? Q2 How do you experience the perceived coercion? Q3 How could coercion be avoided?			two main themes: 'Not being respected as a human being' and 'Being respected as a human being'; these areas covered (involvement in one's care, quality of care, value compared with other people). Alternatives to coercion suggested were preventing coercion lasting too long, voluntary admittance, outpatient care and human contact and better problem solving.
Perceived coercion among committed, detained and voluntary patients (Poulson, H., 1999)	5 closed psychiatric wards at Aarhus University Hospital in Denmark (September 1996-October 1997)	To investigate possible differences in perceived coercion between the group of: admitted involuntarily, admitted involuntarily but later on involuntarily detained, patients admitted voluntarily but without deprivation of liberty. Also to investigate predictors of	N= 143psychiatric inpatients Age: 18-60 yrs (approximately 1/3 from each group)	Semi-structured interviews conducted by a trained medical doctor between day 1 and 5 after deprivation of liberty (for the committed and detained patients) and admission (for control group). Admission Experience Scale (AES) and a Visual Analogue Scale (VAS) measured coercion. Brief Psychiatric Rating Scale (BPRS) was used to measure	Perceived coercion was significantly higher among committed patients, as compared to detained patients. Control group also perceived themselves as coerced. No significant difference was found in relation to age and gender with AES and VAS (coercion levels) respectively or with pathology (BPRS). More patients with schizophrenia in the detained group than the control group (which had more patients with mood disorders). No significant difference was found between committed and detained patients' experiences of coercive strategies such as restraint or forced medication. Commitment considered more coercive than involuntary detention after voluntary admission (according to the VAS but not the AES).

		perceived coercion.		pathology and Global Assessment of Functioning (GAF) measure social functioning of patients. Data was analysed statistically using SPSS.	
Patients' views and readmissions 1 year after involuntary hospitalisation. (Priebe et al., 2009)	Psychiatric inpatient wards from 8 mental health trusts, NHS (England).	Assessed two outcomes of involuntary admissions: 1) involuntary hospital re-admissions within 1 year after the index admission and 2) examined whether patients retrospectively assessed their involuntary index admission as justified.	N= 1570 Involuntary patients recruited in 22 hospitals provided by 8 mental health NHS trusts in England. Age: 18-65yrs. Participants were detained under sections 2, 3 or 4 of the 1983 Mental Health Act. 50% consented to follow-up interviews, 51% of which were re-interviewed at one year.	Observational prospective study with a 1 year follow-up. Baseline variables and readmission data at 1 year were collected for the total sample. A consenting sample was interviewed at baseline and at 4 weeks, 3 months and 1 year. Various data obtained: MacArthur Perceived Coercion Scale, Client's Assessment of Treatment Scale,	15% were involuntarily admitted within the first year; 11% were voluntarily readmitted. Of the group followed up at one year, 40% felt their initial admission had been justified. Demographic factors were also explored, finding that patients receiving welfare benefits, patients who were less satisfied with their treatment and those living with others were more likely to be readmitted involuntarily, as were patients of Black African and Black African-Caribbean origin. Outcomes for involuntary and voluntary admissions were similar.

				Global Assessment of Functioning, Brief Psychiatric Rating Scale. Other methods included Closed questions to participants, 'likert based' questions and information obtained from hospital records.	
Patients' views of involuntary hospital admission after 1 and 3 months: prospective study in 11 European countries (Priebe et al, 2010)	Psychiatric inpatient units across 11 European countries (July-October 2003)	Assessed patients' views on involuntary hospital admission after 1 and 3 months at sites in European countries. Explored whether patients' retrospective views on admission varied between sites in different countries.	N= 2326. Inpatient psychiatric patients who were involuntarily detained. Age: 18 - 65 years.	Assessment of psychopathological symptoms during first week of admission (BPRS; taken as baseline symptom levels). Further face to face interviews were conducted as follow-up 1 month and 3 months after admission. Eg. "Today, do you find it right or wrong that you were admitted to hospital?" (Likert scale response). Sociodemographic and clinical	In the total sample, 55% thought at 1 month that their admission was right and 63% at 3 months. Percentages varied between 39-71% at 1 month and 46-86% at 3 months. Pair-wise post hoc statistical analysis showed that patient views are significantly different between certain countries, even when adjusted for other predictor variables (E.g. views in England were significantly less favourable than seven other countries). Multivariate analysis showed that male patients and those living with others tended to find the admission more often right. Patients with schizophrenia had more negative views than those with other diagnoses.

				information was retrieved from medical notes.	
Coercion and "voluntary" admission: An examination of psychiatric patient views. (Rogers, 1993)	People who had experienced psychiatric inpatient services, nationwide (UK).	To what extent is the label of 'voluntary' an indicator of patients entering and remaining in hospital of their own free will? What were the range of perceptions, beliefs and circumstances surrounding those who had entered hospital as voluntary patients but had felt themselves to be there under duress? What differences of view, if any, exist about treatment and services between those patients who construed	N= 412. Psychiatric patients who had experienced at least one psychiatric admission to hospital. They were surveyed on behalf of MIND. Patients were recruited from statutory services (32%) and voluntary sector agencies (68%). 80% had been voluntarily admitted	Questionnaire (consisting of 241 questions) was administered by volunteers; interviews took 2-3 hours. Statistical analysis (cross tabulation procedures) was used to interpret the findings of closed questions. Open-ended questions were analysed qualitatively.	44% did not regard their 'informal status' to be genuinely informal. Genuinely informal group felt coerced 21% of instances, compared with forced informal group who felt coerced 80% of instances. Those who felt forced were more likely to be unmarried and have a diagnosis of psychosis. 64% felt under duress from professionals; 36% family/friends. People felt coercion at different times and in different ways ranging from 'repressive force' to 'gentle persuasion' (including the use of guilt, threat of losing care of child or employment, deceit and restraint and containment). Those who perceived status to be genuinely informal were more likely to accept a medical account of their experiences and find their diagnosis helpful (77% compared to 59% for each). More likely to feel dissatisfied with service; attitude continued post discharge (14.2% of GI vs. 34% FI found outpatients helpful). Voluntary and compulsory admissions are blurred; coercion is a 'continuum'. Statistics for forcibly detained are likely to be under-estimated.

		their status to be genuinely voluntary compared to those who did not?			
Autonomy and the right to refuse treatment: patients' attitudes after involuntary medication (Schwartz, Vingiano, Bezirganian and Perez, 1988)	Two inpatient psychiatric units at Beth Israel Medical Center, a teaching hospital in New York (US). Conducted in 1986 over a period of 4 months.	To study the subsequent perceptions of psychiatric patients who had initially refused medication but who were ultimately medicated involuntarily (in a 'medical emergency' or as a result of a court order).	N= 25 Psychiatric patients who had been treated involuntarily.	Brief Psychiatric Rating Scale (BPRS) administered at the point of medication and then at discharge. Patients were asked about their non-compliance at discharge and administered the 'Attitude towards involuntary treatment' questionnaire (devised for this study) comprising of 9 questions answered using a 7 point rating scale. Medical charts were reviewed and doctors were	17 patients agreed that the decision to involuntarily medicate them had been correct (labelled 'retrospective compliers'; 8 of whom were male and 9 were female). 7 patients remained 'non-compliers' (3 males and 4 females) because of side effects, felt treatment was unnecessary or reasons unknown. Retrospective compliers had fewer numbers of previous admissions and fewer compulsorily administered medication; they agreed they should be treated in that way again should it be required. Diagnosis was found to be a significant variable; with 'retrospective non compliers' being more likely to suffer from manic-depressive disorders than schizophrenia and to demonstrate grandiose and hostile traits. Wide variation in the attitudes of the compliers and non-compliers. Individual F tests derived from the overall MANOVA procedure revealed significant differences between on 7/8 of the BPRS items at discharge. Compliers scored <2 (very mild) on every item while non-compliers had made little progress. They also scored higher than the compliers on conceptual disorganization, mannerisms and posturing, grandiosity, hostility, suspiciousness, unco-operativeness and unusual thought content.

				interviewed.	
Patients' perceptions of coercion in acute psychiatric wards. An intervention study (Sorgaard, 2004)	Two acute wards at a psychiatric hospital in Northern Norway.	Reduce the overall level of perceived coercion, identify factors associated with perceived coercion and reduce the frequency of aversive events as experienced by patients.	Data from 190 admissions were analysed, 86% of whom agreed to complete measures at discharge.	5 week baseline phase was followed by a 12 week intervention based upon three factors: engage patients in formulating their treatment plan, performing regular joint patient and staff evaluations about the progress and renegotiating treatment plans where necessary. Patient satisfaction (SPRI) and perceived coercion (Coercion Ladder) were measured at discharge for those who consented.	Statistical analysis (non parametric tests and multiple regression analysis) was performed on the data. Intervention did not significantly reduce perception of coercion or increase levels of patient satisfaction. Factors influencing the patients' subjective experience of coercion were seclusion, forced medication and length of stay (with seclusion as the main one). Insulting behaviour, insulting communication, physical harassment, lack of influence on the treatment plan and lack of respect for patient's opinion explained 44% of the variance (with insulting communication being the biggest factor). 33% experienced insulting behaviour from staff, 10% experienced physical assault. Coercion was negatively correlated with three measures of satisfaction (with contact person, their therapist and their treatment as a whole).
Attitudes towards psychiatric hospitalisation: a comparison of involuntary and voluntary patients (Spence, Goldney	Glenside Hospital, (an inner suburban inpatient psychiatric hospital in South Australia (September	To determine the attitudes towards hospitalization of both voluntary and involuntary patients admitted to a state psychiatric	N= 100 Patients had been admitted for at least a week.	1 interview conducted by a CPN. Interview modified from questions previously used (Gove and Fain, 1977); questions	44% had been involuntarily detained at some stage in their current hospital stay. Involuntary patients tended to be significantly younger and better educated and more likely to present with a diagnosis of schizophrenia. Initial attitudes were significantly different; involuntary patients more often felt coerced about admission, more angry about hospitalisation and more likely to deny need

and Costain, 1988)	1983 and June 1984)	hospital.		were asked around experience of hospitalisation in relation to current and retrospective attitudes. Demographic and clinical data was also obtained from medical notes.	for treatment. Current attitudes only differed significantly on two items: involuntary patients still felt coerced at remaining in hospital and felt hospital appeared like a prison.
Previous involuntary commitment is associated with current perceptions of coercion in voluntarily hospitalized patients (Zervakis et al., 2007)	Inpatient psychiatric unit (North Carolina, US) March 2004-December 2005.	To examine the association between past involuntary commitment and current perceptions of coercion in 'voluntary hospitalized veterans' with severe mental illness.	N=205 Voluntary psychiatric inpatient veterans diagnosed with severe mental illness Mean age: 51 years, 88% male, 33% white, 35% married or cohabiting. 29% had a psychotic spectrum disorder, 15% had a severe mood disorder and 57% had PTSD. (39% also had an	Randomised trial of psychiatric advanced directives. Baseline interviews were conducted and medical records were reviewed. Associations were examined using statistical analysis. (including self report questions on personal history and experience of coercion) and medical record reviews (including GAF scores) Coercion measured	Treatment experiences: prior involuntary commitment (39%), being placed in seclusion (30%), being placed in physical restraints (27%), being denied requested medications (26%) and being forced medications (18%). A history of prior involuntary commitment was positively associated with the PCS. Demographic and clinical variables positively associated with the PCS ($p<.10$) were married/cohabiting status, greater than high school education, psychiatric diagnosis and lower GAF scores. The expected number of coercive statements endorsed by those who had a prior involuntary commitment was 1.6 times higher than those who did not have a prior involuntary commitment. Patients with lower GAF scores reported experiencing greater levels of coercion.

			alcohol use disorder and 40% a drug use disorder)	using Perceived Coercion Subscale (AES) Current alcohol and drug use was measured using CAGE questionnaire. Insight was also measured using a rating scale. Health (Veterans SF 12) and subjective social support subscale (Duke Social Support Index).	

1.7 Literature Review

The literature will now be critiqued in relation to the research questions. In order to provide structure and an opportunity for greater critical coherence, papers will be broadly grouped into 'qualitative', 'quantitative' and 'mixed methods'. The two primary questions will be systematically considered in each of these three groups in order to maintain coherence and to help orientate the reader.

1.7.1 Qualitative Papers (N= 4)

An exploratory study of fifteen discharged psychiatric patients who had all been compulsorily detained found all participants reported to have struggled to cope with intense feelings at their admission. These included anger, fear and sadness (Joseph-Kinzelman et al., 1994). For some, these emotional needs were sufficiently met by staff; for many they were not. This study offers a useful insight into the experiences of patients during key stages of the process of involuntary psychiatric detention. It is strengthened by the use of lengthy interviews (lasting between one and three hours) using a schedule which had been piloted as part of a group interview. Despite this, the study lacks clear methodological aims and minimal detail was shared about the participants' diagnosis or previous experience psychiatric services. Lack of methodological rigour diminishes the research as the data was not analysed using any specific qualitative approach, generating only descriptive themes. Conclusions drawn related only to implications for the role of nursing, despite this not being the proposed area of research. Such limitations undermine the value of this research and make it impossible to draw conclusions about the pattern of data, or how to apply it to a specific population.

A study exploring patients' perceptions of involuntary treatment in relation to self, relationships and recovery interviewed participants using a semi-structured schedule (Hughes, Hayward and Finlay, 2009). Half of the participants reported having maintained their sense of self during the admission process, while the other half expressed extreme negative experiences, including 'feeling undervalued'. Although based on a sample size of 12, this research generated important information about the strength of fear experienced by those as a result of an involuntary admission. Purposive sampling was used in the study as a way of accessing the shared experiences of that group. The interviews were however based upon retrospective accounts, ranging from one week to seven years ago. This wide time range not only threatens the homogeneity of the sample it may also make the data vulnerable to memory based biases.

In an IPA study Johansson and Lundman (2002) detailed the experiences of five involuntary hospitalised patients, and reported that they experienced their admissions as both supportive and violating. Interviews were conducted and analysed at three levels. The second stage, which remains closer to the data than the later, more interpretative stage, included a range of themes: 'being restricted in autonomy', 'being violated by intrusion', 'physical integrity and human value', 'being outside', 'being respected as an individual' and 'being cared for'. The research concluded that the findings represent a complex mix of experience within which [they found] "*some staff have failed in their task to see the patients as individuals and respect them*" (Johansson and Lundman, 2002, p.645). It should be noted that five is too small a sample from which to draw firm conclusions, although the purpose of qualitative

research is not to generalise its findings to a wider population. It is also worth considering that the research includes those who wished to share their views; it is possible that those with the most extreme experiences were likely to want to participate in this.

Narrative-based interviews were conducted upon 18 involuntarily hospitalized patients with the aim of exploring attitudes to coercion (Olofsson and Jacobsson, 2001). Qualitative interpretative content analysis was performed on the data and participant responses were primarily grouped into the categories of 'not being respected as a human being' and 'being respected as a human being'. Although a 'descriptive-explorative' approach was reported to have been followed, it is unclear what types of questions were asked. The authors suggested that the fact participants were interviewed prior to their exit to hospital may have contributed to overly favourable reports, either for fear of jeopardising their discharge, or because their perspective was more positive at that point. Interestingly there were 13 eligible patients who refused to participate because of a reluctance to discuss difficult or painful experiences.

1.7.1.1 Qualitative Papers: What are patients' emotional experiences of involuntary psychiatric inpatient care?

The qualitative literature reviewed suggests that in many cases the emotional needs of patients are not being sufficiently met (Joseph-Kinzelman et al., 1994). The feelings encountered by patients include frustration, anger, sadness, fear and boredom (Joseph-Kinzelman et al., 1994; Hughes et al., 2009). Feeling undervalued,

disrespected and powerless were also common experiences (Johansson and Lundman, 2002). Fear was particularly significant in several of the studies. One patient reported the cyclical nature of such an emotion, i.e.: fear led to non compliance, which in turn triggered an increase in the use of coercive methods, and hence greater fear. This indicates the potentially counterintuitive nature of forced medication (Hughes et al., 2009). Restraint and threat to 'physical integrity' was viewed as slightly more coercive than forced medication (Johansson and Lundman, 2002). The latter was found to worsen patient distress, as expressed with this extract: "*They took me to the back room, they put me face down on the bed, actually holding my face into the cushions, so that I couldn't breathe. I was fighting and fighting. And they were saying, um, go on, pull her trousers down and stick it in her arse. I thought they were raping me*" (Hughes et al., 2009, p.157). Some factors not necessarily viewed by professionals to be overtly coercive, were identified as being experienced as forceful, for example 'threats of sanctions' (Olofsson and Jacobsson, 2001) suggesting that the staff perceptions of coercion may not be attuned with patients' experiences.

1.7.1.2 Qualitative Papers: What can be done to help minimise the negative aspects of coercion?

The qualitative literature offers suggestions for how coercion can be minimised; these can broadly be grouped into 'environment and activity' and 'emotional support and communication'. The creation of a 'calm and accepting environment' was deemed important (Joseph-Kinzelman et al, 1994, p.31). Enabling activities and protecting patient privacy would also help to enhance the environment (Joseph-

Kinzelman et al., 1994). Whilst for many patients, involuntary treatment was experienced as positive, a need for greater consistency in care was also identified (Johansson and Lundman, 2002).

Emotional support and communication were identified as being significant factors. Having a positive relationship with staff was found to help preserve a patient's 'sense of self' and reduce their experience of coercion (Hughes et al., 2009). Staff training into the impact of coercion could support a better understanding of this, including the dynamic of disempowerment and how it appears to contribute to greater non-compliance and perpetuate the need for coercion. Patients also desired increased support in managing difficult feelings at admission (Joseph-Kinzelman, 1994). Reducing the length of coercive treatment was suggested as being another way to reduce the associated negative impact, as well as better awareness around voluntary admittance and improved outpatient care (Olofsson and Jacobsson, 2001).

1.7.2 Quantitative Papers (N= 8)

The most common type of coercion was viewed as 'verbal persuasion' in one study which surveyed 105 patients (Lucksted and Courtsey, 1995). They found that 13% had been pressured or forced to take medication in the last year with most reporting emotions of anger and fear and many feeling less inclined to seek help from a hospital in the future. This study benefitted from client input both at the questionnaire design stage and at the point of data analysis. In an attempt to prevent response bias the 61 question survey used a quantitatively analysable multi-option response format within which positive and negative answers were alternated. This

survey was piloted and amended during the design procedure. Test-retest validity was then assessed for by administering the questionnaire twice to a small group; each question was answered similarly by 70% or more of the respondents. Participants were deemed to be representative of patients in the public mental health system, even though they were recruited from rehabilitation centres in Maryland, US, which will have an impact on generalisability.

Schwartz, Vingiano and Bezirganian (1988), surveyed 25 patients who had been subjected to involuntary treatment, finding that decisions to refuse medication were not consistent over time and not indicative of beliefs about treatment or mental illness. Participants were recruited at the point of discharge following experiences of compulsorily administered medication. Their retrospective attitudes towards involuntary commitment were then assessed using a questionnaire created for the study; no mention was given as to whether this tool had been standardised. One strength of this study lies in the use of a range of data collection sources allowing demographic data and clinical information to be incorporated into the analysis. The repeated use of the Brief Psychiatric Rating Scale (BPRS; Overall and Gorham, 1962) provided an opportunity to examine differences in symptoms between the two groups and changes across time. The psychometric properties of the BPRS have been examined extensively (Hedlund and Vieweg, 1980). Whilst it is considered a reliable and valid tool for evaluating psychopathology in patients with schizophrenia, it may have provided a less sensitive measure of the psychopathology of patients with other diagnoses.

The mediating factors of coercion in the context of acute inpatient services were studied (McKenna, Simpson and Laidlaw, 1999). The MacArthur Admission Experience Scale (AES) was administered (Gardner et al., 1993) which is a validated psychometric measure. The study offers a better understanding of the experiences of coercion and the effect of mediating factors. A 'between group' design was used to compare a voluntary and involuntary sample and a strong significant difference was found in the links between patients' legal status and their perception of coercion ($t=-5.29$, $p=.000$). The sample size was determined by a power analysis, ensuring an adequate number of 138 participants were recruited. Correlational analysis revealed a positive relationship between anger and sense of coercion. Correlational designs are however vulnerable to Type 1 and 2 errors and no causal route can be assumed.

In an intervention study Sorgaard (2004) aimed to reduce the overall level of perceived coercion in acute psychiatric wards by implementing a 12 week programme. Despite developing a treatment plan which engaged patients in their care and enabled regular evaluation and negotiation of it, scales used to measure coercion (Iversen, Hoyer, Sexton and Gronli, 2002) and patient satisfaction (Hansson and Hoglund, 1995) demonstrated no improvement in either. The authors reported that many patients claimed to have had little input into their treatment plan, suggesting that the intervention may not have been reliably followed. Two extra questions were added to the schedule relating to the use of patronising communication and physical harassment; these items were not tested for reliability or validity. This study fails to produce reliable conclusions about an effective intervention for alleviating the impact of coercion.

One US study examined the association between past involuntary commitment and current perceptions of coercion in 205 voluntarily hospitalized veterans (Zervakis et al., 2007). A history of prior involuntary hospital admission was positively associated with coercion as measured by the Perceived Coercion Subscale (PCS; Gardner et al., 1993), whilst the effects of other coercive acts (such as seclusion and physical restraint) were not. Data was obtained from baseline interviews as well as clinical record reviews. This study benefitted from the incorporation of a wide range of measures in its design, ensuring many patient variables were explored including a measure for current drug and alcohol use (CAGE; Ewig, 1984), insight into illness severity, demographic, physical health and social support (Koenig et al., 1993) and the Global Assessment of Functioning (GAF; American Psychiatric Association, 1994). The recruitment method ensured only voluntarily admitted patients were surveyed which provided a specific focus upon the impact of previous involuntary admissions. One obvious weakness in this study, however, was the way in which it incorporated only veterans with severe mental illness, more than one third of whom had a substance misuse issue. The findings cannot therefore be generalised. This study also relied upon the self-report of patients regarding their mental health history. This could have made the information less reliable than if it had been obtained from an objective source. Whilst this study offers information on associations between past involuntary commitment, history of coercive hospital experiences, and individual characteristics, such correlations cannot be assumed to be causal.

In a 1996 study, patients' experiences of involuntary pharmacological treatment and restraint were retrospectively assessed (Naber, Kircher and Hessel, 1996). The interview included questions aimed at eliciting patients' experiences and measure insight and memory. The answers to these questions were rated by two psychiatrists before the relationship between variables were statistically analysed. This schedule appears not to have been standardised or validated, making its reliability unclear. Interviews were conducted 60-80 days after discharge, making it again vulnerable to memory bias. Indeed more than 25% of participants could not recall the event fully, leading the authors to hypothesise that memories may have been repressed. This study, having explored experiences of both restraint and injection, failed to distinguish between those two aspects when results were analysed. Further to this, whilst it sought to explore 'retrospective attitudes', the information gained was minimal having been elicited by 12 simple questions.

One large scale prospective study interviewed 2326 involuntarily detained patients from across 11 European countries (Priebe et al., 2010). A range of quantitative measures were used to seek information regarding the appropriateness of admission, socio-demographic and clinical data (BPRS, Hedlund and Vieweg, 1980). Large variation in opinion across Europe was found which was not accounted for by socio-demographic differences, baseline symptom levels or clinical diagnosis. This study is unique, using the largest sample across Europe to date. It is also the first to utilise a standardised method in several countries. Despite the large sample size however, there was a 50% conversion rate from eligibility to participation, meaning many potential participants were not involved. It should also be acknowledged that most

countries involved were represented by measures based only in one hospital, so the findings cannot be generalised to the rest of the country. This should not divert attention from the fact that this is a robust study offering rich data.

Spence, Goldney and Costain (1988) reported a significant difference in the 'initial' attitudes of voluntary and involuntary patients towards their hospitalisation; involuntary patients were more likely to feel coerced, angry and deny their need for treatment. This disparity narrowed once 'current' attitudes were analysed. Whilst clear comparisons are made between the two participant groups, the study's ability to explore attitudes to psychiatric hospitalisation is limited by the use of structured interviews designed to generate quantitative data that can be analysed statistically. Closed questions were asked which could be interpreted as leading, for example "do you think hospitalisation has been harmful?" This could create a response bias which would undermine the findings' validity. Whilst questions were reported to have been modified from previously established interview schedules (Shannon,1976; Gove and Fain, 1977) it is unclear whether the revised items were standardised. Further to this, the samples were dissimilar according to key features such as age, diagnosis and history of voluntary admission; this threatens the validity of any comparative findings

1.7.2.1 Quantitative Papers: What are patients' emotional experiences of psychiatric inpatient care?

The quantitative literature suggests that anger is a core emotion experienced by those in inpatient psychiatric care (Lucksted and Courtsey, 1995; McKenna et al., 1999;

Spence et al., 1988). The experience of anger is thought not only to impact upon perceived levels of coerciveness (McKenna et al., 1999) but left patients less inclined to seek help from hospital in the future (Lucksted and Courtsey, 1995). Denial was also hypothesised to be prominent (Spence et al., 1988). There exists therefore a complicated relationship between the emotional experiences of a patient and their experiences of coercion. Patients' resistance to treatment was found to be changeable by one study, suggesting volatility in expressed attitudes and emotions (Schwartz et al., 1988). Further to this, experiences of being disrespected and physically assaulted were reported, as well as feelings of powerlessness in relation to the treatment plan (Sorgaard, 2004). Patients' individual differences (such as gender, previous experience and internal sense of autonomy) have also been found to impact upon their sense of coercion (McKenna et al., 1999). This is particularly true for past experiences of involuntary treatment (Zervakis et al., 2007).

1.7.2.2 Quantitative Papers: What can be done to help minimise the negative aspects of coercion?

Not all of the quantitative papers directly addressed the question of how negative aspects of coercion could be minimised (Lucksted and Courtsey, 1995; McKenna et al., 1999). Despite this, suggestions can be made based upon their results. The finding that those who function at a lower level are likely to experience a greater sense of coerciveness (Zervakis et al., 2007) could inform the offer of direct work for the most vulnerable clients. The fact that experiences of compulsory admission are likely to make patients comply less in the future perhaps indicates the need for sparing use of involuntary powers (Schwartz et al., 1988). Restraint, specifically,

was viewed as slightly more coercive than forced medication (Naber et al., 1996). The use of seclusion may also require greater consideration as it was a measure which particularly increased levels of perceived coercion (Sorgaard, 2004). It should be remembered however that coercion appears to be more acceptable to a patient as they progress through the system (Priebe et al., 2010). An increase in patient participation with their treatment plan and improvements in communication with staff may be helpful in minimising the impact of coercion (McKenna et al., 1999; Sorgaard, 2004). Good communication during the early stage of admission seems particularly important in reducing patients' anxiety given that this is when coercive practices were most found to be used (Naber et al., 1996). An increase in the reflective practice of staff may benefit the provision of better emotional support for patients (Spence et al., 1988); this could be achieved through increased supervision or reflective practice groups.

1.7.3 Mixed Methods Papers (N= 7)

A large UK study involving 1570 participants across eight mental health trusts sought to assess outcomes of involuntary admissions (Priebe et al., 2009). They found that patients, who expressed a lower satisfaction with hospital care within the first week of involuntary admission, were more likely to be involuntarily readmitted within 1 year. Those with higher levels of functioning were less likely to view their involuntary admission as justified, suggesting that those with poorer levels of functioning felt they had benefitted from the admission. One of the greatest strengths of this study is the scale and breadth of information it generated by using a range of sources for data collection. The use of purposive sampling ensured

participants were recruited from a range of geographical locations. The study was mixed methods in the way that it incorporated qualitative interviews for half of the participants recruited along with the use of clinical measurements, patient-rated measures (Gardner et al., 2003) and administrative information which were analysed statistically. The observational nature of this study however means that it is unable to draw conclusions from the causality of the associations found. Whilst some participant differences between those interviewed and those not interviewed were accounted for in the statistical analysis, there could be further biases unaccounted for in the population of patients who were not interviewed at the baseline stage.

Another UK study explored the extent to which the legal term 'voluntary status' describes the experience of the patient (Rogers, 1993). A 241 item questionnaire consisting of a mixture of qualitative and quantitative questions was administered. Whilst the survey was piloted, no mention was made of it being standardised or validated, thus the validity of its findings are weakened. Duress was reported to consist of a variety of components ranging from 'repressive force' to 'gentle persuasion.' The study concluded that coercion was on a continuum, with the likelihood being that so called voluntary admissions underestimate the use of involuntary and coercive practices. This research offered a comprehensive measure for assessing the perception of voluntary and involuntary status, its strength lying in the inclusion of both qualitative and quantitative questions. The use of 54 open-ended responses to the question "If pressurized, please give details of who pressurized you and how?" generated data on the nature of physical and psychological coercion. Despite this, in an attempt to create questions which could

be analysed quantitatively, closed questions were asked, for example: "*do you feel your choice was a real one*?" This could be interpreted as leading and therefore create a bias in responses due to participants being unable to express themselves clearly. The considerable length of the questionnaire may have also contributed to the large number of unanswered items; though no mention was made of how many and incomplete questionnaires were still analysed. Another weakness was that the data did not account for time in hospital, diagnosis, or how recent or frequent hospital stays were.

A Danish study of 143 patients in closed psychiatric wards investigated possible differences in perceived coercion of patients with different legal statuses (Poulsen, 1999). The data was collected using a semi-structured, validated interview schedule (AES; Gardner et al., 1993) and a range of measures to assess perception of coercion (Visual Analogue Scale, Cantril, 1965) psychopathology (BPRS; Overall and Gorham, 1962) and general functioning (GAF; American Psychiatric Association, 1994) were also used. Perceived coercion was found to be significantly higher among involuntarily committed patients than patients involuntarily detained after a voluntary admission, although no difference was found between the groups in the experiences of restraint or forced coercion. The attrition rate was 20.6%; the use of a chi square test found that the involuntarily committed group more often refused to participate than either of the other two groups. This suggests that a selection bias inadvertently occurred. The 'control' group (patients admitted voluntarily and remaining in hospital without compulsion) also reported feeling coerced. Relatively little information however is offered on patients' personal experience or how they

define the coercion that is measured so rigorously. Another weakness lies in the fact that the AES was not designed to measure perceived coercion among detained patients. The authors report it could therefore be argued that the difference in the findings between the AES and the VAS could be attributed to the AES being used beyond its original purpose.

An Irish study exploring inpatient experience of the involuntary admission process was conducted by interviewing 81 patients from a psychiatric hospital (O'Donoghue et al., 2010). A standardised measure to assess awareness (Scale to Assess Unawareness of Mental Disorder; Amador et al., 1994) was also administered, as well as information being obtained from medical notes. The two factors found to reliably predict perceived necessity were length of admission and level of awareness of illness. This study failed to control for symptom severity or level of functioning which meant that the influences of these factors were overlooked. Findings therefore cannot be meaningfully compared to the UK population. It is also possible that patients reported favourable opinions out of concern that their responses may impact upon their discharge date.

Patients' perceptions of coercion were explored in a study of participants staying in one of four psychiatric units in the US state of North Carolina, (Hiday, Swartz, Swanson and Wagner, 1997). 331 involuntarily admitted patients, just over half of which had a diagnosis of schizophrenia, were administered an extensive interview incorporating areas such as diagnostic assessment, measures of health and mental health functioning and 15 true-false items of the MacArthur Interpersonal Relations

Scale (Gardner et al., 1993). These items were used to construct three dependent variables: perceived coercion (measured using the PCS; Gardner et al., 1993), perceived negative pressures (rated by a six item scale created for this study) and perceived procedural inequity (which included an evaluation of the motivation of others), variables which were strongly associated with each other. This study was rigorous, basing its findings upon the use of a variety of assessment tools. The fact that patients were offered extra services and monetary incentives to participate however may be considered unethical. Further to this, because participants were recruited from a larger study of patients receiving outpatient commitment, they were interviewed whilst preparing to leave hospital under the powers of compulsory community treatment. This may have biased the reported experiences of coercion.

A US study of 59 patients with psychosis explored the opinions of participants regarding inpatient psychiatric treatment (Kaltiala-Heino, 1996). Two structured interviews were conducted, the first a week after treatment, the second six months after discharge. No mention was given as to whether these interviews were standardised or validated. Other measures of functioning and psychopathology (BPRS; Overall and Gorham, 1962) were also administered, again ensuring diversity in the data gathered. Whilst the legal status of the interviewees did not distinguish between their opinions, the patients' personal experience of being coerced was related to less favourable attitudes. The initial sample of 100 patients was reduced by an attrition rate of 41%. Reasons for this included participants choosing only to participate in the first stage, subsequent withdrawal, loss of contact and suicide. All of these factors could have biased the data gathered from the remaining sample. It

should also be acknowledged that the data is only representative of patients with psychosis and therefore offers limited generalisability.

Bradford, McCann and Merskey (1986) looked at 57 involuntary psychiatric patients' attitudes towards their compulsory admissions. Data was collected while patients were still in hospital and obtained by administering a questionnaire based interview. Despite the involuntary status of their detention, 81% of patients reported having been helped by their stay, of which 67% indicated they had received help for emotional problems. The use of a structured interview measure generated quantitative data which was then analysed using descriptive statistics. Overall, this study offered information on the general attitudes of patients treated involuntarily. Despite this, the fact that 'length of stay' was not accounted for makes it unclear at which point the patients' attitudes to their detention might have changed. This study adopted a mixed methods design because of its incorporation of one open ended question which offered participants to make a general comment on their stay. These responses were reported simply by stating the percentage of 'positive' and 'negative' statements; it is likely that as a result some meaningful data would have been lost which raises a question around the utility of such a question.

1.7.3.1 Mixed Methods Papers: What are patients' emotional experiences of involuntary psychiatric inpatient care?

Much of the research using mixed methods does not focus on the emotional experiences of patients (Priebe et al., 2009; O'Donoghue et al., 2008; Hiday et al., 1997; Rogers, 1993). However, all papers explored the concept of 'levels of'

coercion and its relationship with other variables. One study identified a range of techniques used which may not typically be considered coercive by others, for example threat of losing employment or care of child, guilt and deceit (Rogers, 1993). Such measures are likely to have an emotional component for those subjected to them. The physical act of commitment itself was found to be more coercive than the subsequent detention for many participants (Poulsen, 1999). This was thought to be influenced by the presence of police and reiterate the significance of the admission process and its likely impact on emotions. The sense of being coerced was found to be high in both voluntary and involuntary groups (Poulsen, 1999) and has been found to have lessened during hospitalisation (Kaltiala-Heino, 1996). 35% of one sample were retrospectively positive about their stay whilst 23% continued to appreciate nothing of theirs (Bradford et al., 1986).

1.7.3.2 Mixed Methods Papers: What can be done to help minimise the negative aspects of coercion?

Given the reported link between patients' views of their care and their clinical outcomes, (Priebe et al., 2009) the attitudes of patients should perhaps be sought routinely so that concerns could be addressed as they arise. Patient satisfaction as a prognostic indicator could pose a useful tool in ensuring successful interventions and minimising the negative aspects of coercion. This could be enhanced through improved communication between staff and patients (Priebe et al., 2009). Ward staff play a significant role in patients' experience and a fuller explanation of treatment and legal status at the point of admission would also decrease anxiety for many (Bradford et al., 1986). The fact that coercion is experienced by voluntary patients

too means that the experience of patients with such a status should not be overlooked (Kaltiala-Heino, 1996). Alternative forms of duress from staff and family, including persuasion and the use of guilt, should also be monitored as they are likely to occur in a less explicit way and amplify the negative aspects of coercion (Rogers, 1993). Coercion is not thought to relate to symptomatology and so cannot be attributed to illness (Poulsen, 1999). The two factors found to reliably predict perceived necessity were length of admission and level of insight into symptoms (O'Donoghue et al., 2010). This means that interventions seeking to improve awareness may help to alleviate the distress caused by coercion. During treatment the positive and negative impact of the family should be considered (O'Donoghue et al., 2010); this might be achieved by a holistic approach to care where all aspects of a patients' experiences are valued. The fact that 81% of patients in one study reported to have been helped by their hospitalisation demonstrates the possibility for positive experience. These benefits were thought to have been achieved through improving interaction with family members and supporting emotional problems, findings which offer guidance to future clinical practice (Bradford et al., 1986). In the same study only 19% reported that their basic needs were well provided for meaning that improvements in practical areas such as meal times could also reduce the negative impact of coercion. Others described being bored and complained about their proximity to others (Bradford et al., 1986); such concerns could be alleviated through an increase in activity and attempts to create privacy on the ward.

1.8 Discussion

1.8.1 Summary of Findings

Patients' experiences of coercion in psychiatric care are varied and do not necessarily relate to the legal status under which they are placed. Coercion occurs in many forms at different stages of the treatment process and is reported to change over time. The admission phase is thought to be a particularly significant time and seclusion and restraint are viewed as more coercive than detention. Key emotions relating to the experiences of coercion include fear, anger and sadness. Most patients admitted involuntarily, retrospectively perceive their admission as necessary, and often helpful. Negative experiences are also thought to impact upon prognosis, engagement and later attitudes to accessing care. Many patients felt disrespected and undervalued when under coercive powers, although some shared experiences of good care they had received from staff. Several ways of minimising the negative impact of coercion have been discussed and include routinely seeking patients' views, monitoring the use of 'unregulated coercion', careful consideration of the use of seclusion and attempts to reduce the length of coercive care. Enhancing the quality of the hospital environment by attending to basic and psychological needs such as food, privacy, occupation and emotional support is also likely to improve patients' experiences.

1.8.2 Critical Account

Whilst a critical account of the research has already been offered, a brief account of general weaknesses to research in this area will now be reported. This will be followed by an acknowledgement of possible weaknesses of this review.

1.8.2.1 Critique of Research

The selection of participants poses an interesting issue in such research. The very nature of studies investigating patients' attitudes relies upon participants to have the capacity to consent to participate and to be sufficiently lucid to communicate coherent responses. Given that the desired sample were people experiencing extreme mental health difficulties, it is likely that some of the most vulnerable participants may not have been involved. There are also likely to have been participants lost due to the timing of such studies, for example some were interviewed after a week in hospital, meaning that any shorter stays would not have been registered (Spence et al., 1988). The studies reviewed conducted their research at various times including anything from whilst a patient was in hospital, up to seven years afterwards. This raises an interesting question around when it is most appropriate to explore such experiences, and at which point the responses are most accurate.

The fact that much of the research was conducted by hospital staff, may mean that some patients may have avoided participating out of concern over how it may affect their care. In spite of this, most recruitment rates were deemed to be representative according to their sample size. It is also possible that those keen to participate may represent those with a particularly positive or negative experience of coercive care. A wide range of methodological approaches were reviewed, each with their strengths and weaknesses. The use of structured, standardised questionnaires generates data which is clear to analyse and comparable with other studies. However they can be criticised for focussing upon phenomena identified by professionals, rather than

starting with the experiences of the patient. The qualitative research reviewed offers rich data based upon an attempt to directly access patients' experiences and the use of quotations often make such an exploration particularly meaningful. However, such research is often restricted to small sample sizes and therefore it is impossible to generalise to a wider population.

1.8.2.2 Critique of Review

This review sought to collate research surrounding the use of coercion in psychiatric inpatient settings and in doing so draws upon information using different methodologies, in various settings across a number of countries. The benefit of this is that a diverse range of literature has been drawn together, to inform a review based upon the concept of coercion in psychiatric inpatient settings. One of the drawbacks of this approach is the fact that countries differ in their admission procedure, meaning that the experience being researched will also inevitably vary. An example of this would be the way that since the 1970's, the mental health laws of many jurisdictions have been amended to limit involuntary admission to those who have been assessed as dangerous to themselves or others. This element is known as the 'obligatory dangerousness criteria' (ODC) and is a feature of the mental health acts of all states of the USA and Australia, five Canadian provinces and six European countries (Large, Nielssen, Ryan and Hayes, 2007). In contrast, the mental health acts of the remaining Canadian provinces and European nations, including the UK, usually allow for involuntary treatment on the basis of the patient being unable to give consent, rather than deemed to be dangerous. This means that, despite attempting to use terms which describe an apparently homogenous group,

differences between groups may be overlooked. In addition to this, it was also difficult to employ a 'quality control' check suitable for all papers because of the diverse nature of the research used. Using only peer reviewed, published journal articles sought to address this issue to some extent, it is recognised though that only reviewing published papers may have resulted in an overestimation of treatment effects. It is also possible that some papers addressing the area of interest may have been overlooked as a result of the choice of search terms, for example a paper entitled 'perceived coercion', which did not mention who such coercion was perceived by, would not have been included.

1.8.3 Clinical Implications

In light of the fact that clinical implications have been explored by way of answering the second research question, this section will consist merely of a summary of key points.

- **Patient** satisfaction is an important indicator of prognosis and impacts upon later experiences of treatment (Zervakis et al., 2007). Patients have reported that they often do not feel respected in the process of involuntary care and that feelings of fear, powerlessness, sadness and rage can make this more difficult. They would like to feel heard and have their individual experiences valued. Care should be taken to address these issues by actively seeking to explore patients' hopes and fears and to maintain a focus on their emotional wellbeing throughout their hospitalization and beyond.
- **Systems and Processes** should be managed in a way which enables staff to offer patients the care that they need; this may include increased supervision

of ‘frontline’ staff and a higher ratio of staff to clients on wards. The admission process is a highly significant period (Poulsen, 1999) and attempts should be made to create choice for a patient wherever possible. Clarity of communication is key to this (Olofsson and Norberg, 2001). It should also be acknowledged that patients’ perceptions of coercion may not always coincide with those held by the system, and that voluntary patients may be just as likely to experience coercion.

- **Clinical Staff** should be supported in their work with this client group, whilst acknowledging the emotional demands of being involved in coercion. The importance of respecting and actively listening to clients (McKenna et al., 1999), and involving them in their care wherever possible, should not be overlooked. Training and supervision could be key to the success of this.

1.8.4 Further Research

Further research in this area is required to explore how patients can best be involved in decisions around their treatment. Related to this is the need for more effective communication between staff and patients on the ward; this is also an area which could benefit from research. Research could be conducted on the impact of coercion on treatment adherence in the community, and subsequent therapeutic outcomes. Future studies could also attempt to better understand the experiences of patients prior to admission and the perspective of the family.

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Chapter Two: Empirical Study

Assertive Outreach Clinicians' experiences of using Community Treatment Orders: An Interpretative Phenomenological Study

This paper has broadly been prepared in accordance with the requirements of the British Journal of Clinical Psychology. Supplementary information is presented within the thesis chapter to aid overall cohesion; this will be removed prior to journal submission in order to reduce the word count.

Word Count: 7661 (Exclusive of figures, tables and illustrative extracts)

2.1 Abstract

Since their introduction to the UK in 2008, Community Treatment Orders (CTOs) have been used to deliver compulsory mental health treatment in community settings. There is a paucity of research into this development in treatment. Assertive Outreach (AOT) is a model of working with clients with severe and enduring mental illness who typically have poor engagement with traditional services (Burns and Firn, 2002). This research is the first known study to explore the experiences of multidisciplinary staff working in an NHS AOT setting. 8 participants were interviewed using a semi-structured schedule. Information was gained on issues such as how the introduction of CTOs had impacted the clinician's role, and their perceived impact upon the client. Interpretative Phenomenological Analysis (IPA) was then used to analyse each interview both at an individual and group level. Three superordinate themes emerged from the interview data: 'control', 'managing the process' and 'congruence'. The findings emphasise the individual way in which clients were perceived to respond to the implementation of the CTO and explore the tension that staff experience between the use of engagement and coercion. The importance of collaborative team working is highlighted and clinical implications are discussed in more detail. Suggestions are made for further research including exploration into the experiences of staff in other settings, and a more detailed analysis of the impact of CTOs upon the therapeutic relationship.

2.2 Introduction

2.2.1 Community Treatment Orders: The Context

The term 'Community Treatment Order' (CTO) refers to a method of delivering compulsory mental health treatment in community settings (Department of Health, 2008). It is aimed at clients who may demonstrate risk; either *of* non-compliance or *resulting from* non-compliance. The CTO can be used with clients who have been detained under the Mental Health Act (2007) and is implemented at the point of discharge; clients are then subjected to certain restrictions in the community. These are written in the form of criteria and typically include stipulations around address, treatment adherence and engagement with services. If the agreed criteria are not met, clients can then be recalled to hospital. CTOs were first introduced in the USA in the 1970's, and have now been adopted worldwide (O'Brien, McKenna and Kydd, 2009). They are used in at least forty one out of fifty states in the USA, two out of ten Canadian provinces, Australia, New Zealand, Scotland and most recently have been introduced to England (Gray, and O'Reilly, 2005) as an update to the 1983 Mental Health Act.

2.2.2 CTO: The Purpose and the Process

The order is intended for those who are ready to be discharged from hospital, but for whom there is a risk of deterioration once in the community (Care Quality Commission, 2010). It is especially aimed at meeting the needs of those who may be "caught in a long term cycle of relapse and re-admission" (Department of Health, p.10, 2008). The intention is that clients are accorded more independence through being able to be monitored and treated at home rather than in hospital. It is suggested that this process offers the least restrictive option for mental health care, whilst actively working to reduce relapse (Gray and O'Reilly, 2005).

A client's suitability for a CTO is determined by their Responsible Clinician (RC) and an Approved Mental Health Professional (AMHP). Although the CTO denotes a form of *compulsory* treatment, clients are required to provide informed consent, thus technically entering into the process voluntarily. Clients can be recalled under certain criteria and there are clear guidelines relating to the process of revocation to hospital. CTOs are reviewed regularly and can be ended by the RC at any time (Department of Health, 2008).

2.2.3 Targeted CTO population

Australian research on the social and demographic characteristics of 164 people on CTOs found that they were more prevalent amongst forty year old males with a diagnosis of schizophrenia, most of whom lived alone and were unemployed (Brophy, Reece and McDermott, 2006). Subsequent audits conducted in the UK support these findings and identify the overrepresentation of black and minority ethnic groups (Inglis and Cupitt, 2010; Evans, Makala, Humphreys and Mohan, 2010). A report conducted by the Care Quality Commission (CQC) found that 4,107 CTOs had been used in the first full year since their introduction; this equates to ten times the number anticipated (CQC, 2010).

2.2.4 Efficacy of CTOs

A range of studies have been conducted which may indicate the usefulness of the CTO. One US study comparing 'outpatient commitment' with 'voluntary care' demonstrated a significant reduction in inpatient admissions and prevalence of arrests in the committed group one year later (Swartz et al., 1999). Epidemiological studies in Western Australia found that although CTOs were not associated with reduced admissions or mean bed-days, there was a reduction in hospital stays

exceeding 100 days (Kisely, Campbell, Preston and Xiao, 2006). Research in Ohio, USA demonstrated an increase in the number of community services and social support services available to those issued with a CTO, suggesting that these secondary benefits may also confound the direct conclusions regarding their success (O'Brien, Farrell and Faulkner, 2009). Methodological difficulties in many outcome studies mean there remains a lack of convincing evidence that CTOs are 'effective'; there is often a failure to account for important variables such as the interim period of inpatient admission and changes in medication (Lambert, Singh and Patel, 2009) or the impact of social interventions which may also contribute to recovery (Appelbaum, 2001). It is therefore difficult to establish a 'measure' of success. In spite of stated limitations there is an evidence base which suggests CTOs may be useful. The existence of evidence to support the clinical utility of the CTO may suggest to some that they might benefit clients; however there remains mixed opinion amongst professionals as to whether, despite this, they should be used.

2.2.5 CTOs: Controversy

CTOs inspire controversy for a range of reasons. The absence of empirical evidence for their effectiveness, combined with difficulties in research design has created a degree of ambivalence in those who work with them (Dawson, Romans, Gibbs and Ratter, 2003; Dawson, 2006; Mullen, Dawson and Gibbs, 2006). A recent Cochrane review found no statistically significant difference between CTO and control groups in terms of hospital outcomes such as admissions, length of stay, contact with services, and compliance with treatment (Kisely, Campbell and Preston, 2011). Even when improvement is clear, it can be difficult to separate which part of the outcome is associated with the use of compulsion, and which the associated increase in community management (Swartz, Swanson, Wagner, Burns and Hiday, 2001). There is also fear that they could be applied inconsistently, with ultimate

responsibility resting upon a clinician's subjective judgement (Dawson, 2007, p.42; O'Reilly, 2004). One recent audit report commented on "the variety of discretionary conditions" which could raise questions around the creativity of its use (Malik and Hussein, 2009, p.437). There is also evidence that CTOs are being used with a broader range of clients than those intended: A recent report in the UK found that out of a sample of 200 patients on a CTO, 30% did not have a history of non-compliance or disengagement, raising an issue about how decisions are being made (CQC, 2010). The fact that many clients are discharged just before legal proceedings are due, could suggest that professionals are not using CTOs appropriately (Carney, 2003). The mental health charity Mind has also reported serious concerns that CTOs may fail to benefit patients, as well as subject people to compulsory powers when it is neither necessary nor appropriate (Mind, 2007).

2.2.6 Perceptions of Staff

Attitudes towards CTOs amongst professionals seem to vary, whilst some appreciate the capacity it provides for 'clinical wisdom' (Brophy et al., 2006; Muirhead, 2000; Power, 1998), others report that whilst greater choice of service provision is enabled, there remains fear of clients being disempowered (Brophy and Ring, 2004). Arguments against CTOs cite lack of an evidence base, increased overall use of compulsion, ethical concerns and a distraction to providing 'good quality' community care (Dawson et al., 2003; Dawson, 2007; Kisely et al., 2011; Mind, 2007). Those in favour of CTOs claim that fears of legitimacy should not prevent its use *per se*, merely encourage strict implementation guidelines (Lawton-Smith, Dawson and Burns, 2008). Some consider that the use of CTOs are likely to alienate clients and unnecessarily increase the use of neuroleptic medication, whilst leaving psychiatrists vulnerable to criticism for inadvertently claiming they can prevent 'risk' through their use (Moncrieff and Smyth, 1999). Critics of CTO suggest that

rather than promoting independence, they actually restrict *more* people in *more* creative ways. This fear is encapsulated in the concept of "net-widening" (Geller, Fisher, Grudzinskas, Clayfield and Lawlor, 2006, p.551). Amongst clients and carers there seems to be a general consensus that compulsory treatment is required (Brophy and Ring, 2004; McDonnell & Bartholemew, 1997). Interestingly a recent survey of psychiatrists in England and Wales found that clinicians were generally positive about the powers of CTOs and that their opinion of them had improved since they had gained experience of them (Manning, Molodynski, Rugkasa, Dawson and Burns, 2011).

2.2.7 Client and Carer Perspectives

A qualitative study of ten women in New Zealand concluded that overall, clients felt that the benefits (a greater sense of safety and better access to services) outweighed the costs ('threat' of hospital and perception of stigma) (Gibbs, 2010). A further New Zealand study examining the views of forty two people who had been placed on a CTO in the previous 2 years, found that the majority viewed the CTO as a "helpful step towards community stability" (Gibbs, Dawson, Ansley and Mullen, 2005, p.357). Despite evidence of client positivity, not all attitudes are entirely favourable. A different qualitative study in New Zealand found that although perceptions of coercion in involuntary outpatients were low, they were significantly higher than that of the voluntary group (McKenna, Simpson and Coverdale, 2006). In fact the fear of forced treatment has been found to be a barrier to engagement in inpatient settings (Van Dorn, ElBogen, Redlich, Swanson, Swartz and Mustillo, 2006) as has the feared disempowerment of clients echoed by a CQC report into the use of the mental health act. The report identified wide variation in the quality of patient involvement when deciding upon treatment, and a lack of patient understanding about the process (CQC, 2010; Williams, 2010).

2.2.8 Assertive Outreach

Assertive Outreach Teams (AOTs) are potentially the most likely to regularly work with clients who are on CTOs, given the background of their target population. Assertive Outreach is a model of working with clients with severe and enduring mental illness who typically have poor engagement with traditional services and have a history of repeated hospital admissions (Schneider, Brandon, Wooff, Carpenter and Paxton, 2006). It is a proactive, flexible approach working beyond the typical hospital or clinic based settings. Clients are seen frequently and supported in a holistic way, for example with issues such as accommodation and physical health (The Sainsbury Centre, 2001). AOTs place an emphasis upon the therapeutic relationship and have been found to be effective at maintaining engagement. A meta-analysis of nine studies reported that 84% of AOT clients still received services after a year, compared to 54% of controls. The mean annual rate of inpatient bed days was also found to have declined by at least 50% (Bond, McGrew and Fekete, 1995).

2.2.9 Summary of Gaps in the Literature and Research Rationale

On an international level there is a fairly diverse literature base covering staff and client attitudes to CTOs using different methodologies; however, there is currently limited research addressing these specific issues in England since their introduction in 2008. The use of CTOs requires a multidisciplinary approach and because of this, clinicians from a range of backgrounds are required to work with legislation which clearly requires engagement with practical, ethical, and legal issues. It is therefore important that their views are considered when reflecting upon the implementation of CTOs, particularly given the subjective way that they could be used (Carney, 2003; CQC, 2010). The literature has suggested a number of potential benefits of the CTO, whilst also offering potential concerns. Studies conducted on staff working

with CTOs in other countries, suggest that attitudes are often mixed. It is important that these issues are explored in detail at a more local level in order to inform clinical practice. The therapeutic relationship, (Moncrieff and Smyth, 1999) is key to such work and it is important to consider how the introduction of a coercive measure has impacted upon the experiences of AOT staff. Staff attitudes have been explored in other countries and these findings can offer valuable areas to explore in England, but there is no known research into the way CTOs are perceived within an AOT. This research would benefit from being qualitative in design to ensure a capacity for diversity in experience and opinion. Information on staff experiences of CTOs would enable a greater understanding of the way that they are perceived, utilised and managed.

2.3 Research Aims

The aim of the research is to explore AOT clinicians' experiences of working with clients on CTOs. The key research questions are:

1. What are clinicians' experiences of working with CTO?

Particular interest lies in their perceived usefulness, the practical processes involved and their impact on the professional role.

2. What impact does a CTO have on a client?

Of particular interest is how this relates to issues of risk, engagement, relapse and access to broader support.

2.4 Method

2.4.1 Ethical Approval

The research proposal underwent a peer review process at the Research Registry Unit at Coventry University (see Appendix 4) before ethical approval was granted by the Comprehensive Local Research Network for the South West Midlands area (see Appendix 5) and the Coventry and Warwickshire region of the West Midlands National Research Ethics Service (see Appendix 6). The research was managed in accordance with ethical guidance from the British Psychological Society (BPS, 2005; 2009a; 2009b).

2.4.2 Design

Eight multidisciplinary team members of an AOT were interviewed about their experiences of working with clients on CTOs. Interpretative Phenomenological Analysis (IPA) was deemed the most appropriate method of analysis because of its focus upon describing the meanings attributed by people to their subjective experience (Smith, 1996; Smith, 2003; Smith and Osborn, 2003).

Yardley offers four broad principles for assessing the quality of research: 'sensitivity to context', 'commitment and rigour', 'transparency and coherence' and 'impact and importance' (Yardley, 2000). The research has been conducted in a contextually appropriate setting and is informed by relevant literature. Commitment and rigour has been demonstrated through the thorough analysis applied to the data and in the researcher's attempts to develop her personal competencies in using IPA. All parts of the process have been documented and findings are shared in an open way, thus ensuring transparency. The research has arisen out of legislative changes which

affect a wide population and clinical implications have been generated in order to meet the principle of impact and importance.

IPA is a qualitative method influenced by the theoretical underpinnings of phenomenological, interpretative and idiographic approaches. The phenomenological aspect of the approach means that it is concerned with how the world appears according to our experience; phenomenological research therefore is not based upon a pre-existing set of theory or hypotheses. IPA is also interpretative in nature because of its stance that no-one has direct access to the understanding of another. There is therefore a double hermeneutic involved whereby the researcher contributes their experience to the process of attempting to make sense of the words of another as they in turn make sense of their own experience. At the same time IPA is idiographic in the way that it focuses on line by line accounts and upon the thorough analysis of individual data (Shinebourne, 2011). Wider themes are then established as the data set is analysed as a whole (see Appendix 11).

2.4.3 Researcher Position

The lead researcher was employed by a local NHS Trust during the time of the interviews. The researcher had worked for a year as a residential support worker for women with severe and enduring mental health difficulties in the past, but had no experience of working with an assertive outreach population. A day was spent visiting the team twelve months prior to data collection (see Appendix 9).

2.4.4 Participants and Recruitment

Inclusion criteria required participants to have worked within the team for two years preceding the interview and have had experience of working with someone on a CTO. The research aimed to draw upon a range of perspectives and so team members from a variety of professional backgrounds were encouraged to participate.

Ethical approval permitted access to the four Assertive Outreach teams in the trust, providing a potential number of forty participants. The lead researcher attended a team meeting in September 2011 and presented information about the research. Staff were asked to register their interest by 'signing up' for an interview, for which 8 team members registered. One clinician from another team within the service was approached in order to broaden the range of disciplines involved. Interviews were conducted over eight weeks between September and November 2011 and lasted a mean average of 59 minutes. Members of five different professions were involved in the study. Table 2.1 outlines the participants' profile.

Participants were given pseudonyms during the analysis stage in an attempt to preserve anonymity. However, it was made clear that each transcript would be analysed individually and any direct quotation could be used in the final report. Participants were also made aware that they could withdraw from the study up to one month following their interview. Interview transcripts were stored in a lockable cabinet. The researcher used encrypted online data back-up to ensure the safe storage of all electronic participant data.

Table 2.1: Participants professional discipline

Interview	Name	Role
1	Katherine	Community Psychiatric Nurse (CPN)
2	James	Social Worker
3	Diane	Clinical Psychologist
4	Chloe	Occupational Therapist
5	Heather	Social Worker
6	Jane	CPN
7	David	Consultant Psychiatrist
8	Sam	CPN

2.4.5 Materials

A semi-structured interview schedule was developed which included a set of questions of interest and follow-up prompts (see Appendix 10). These questions were based upon the research aims and sought to explore the experiences of staff regarding key issues relating to CTOs. The schedule was developed in line with themes which arose from the literature and adapted following consultation of guidelines developed by Smith, Flowers and Larkin (2009) as well as discussion with supervisors. The wording of certain questions was adapted as the interviews progressed, and although not all questions were necessarily asked in the same way, each topic was covered in every interview. Other materials used included the participant information sheet and consent form (See Appendix 7; Appendix 8).

2.4.6 Interview Procedure

Having being given the opportunity to read and discuss the Participant Information Sheet (see Appendix 7) participants were asked to sign a consent form before they were interviewed; this was witnessed and countersigned by the interviewer (see

Appendix 8). Interviews took place in a suitably private NHS office at a location convenient to the participant. All interviews were recorded and transcribed verbatim and participants were made aware of this before they participated. In most cases a transcription of each interview was completed within 48 hours of the interview and usually before the next interview took place. In order to help protect anonymity, participants' pseudonyms were attached to their interview transcript (Banister, Burman, Parker, Taylor and Tindall, 1994).

2.4.7 Analysis

The transcripts were analysed according to the principles of Interpretative Phenomenological Analysis (Smith, Flowers and Larkin, 2009). The heuristic framework of Smith, Flowers and Larkin was referred to as a guide to the process. These principles were followed closely as described in Table 2.2 (Gee, 2011). An excerpt from the transcripts is provided to demonstrate the analysis conducted (see Appendix 12); participant themes are also presented (see Appendix 13).

2.4.8 Credibility of Analysis

The subjective nature of qualitative methods requires attempts to ensure the credibility of analysis (Elliot, Fisher and Rennie, 1999). The data analysis was audited at various points throughout the process as outlined in Table 2.3. Recurrence of themes was also monitored to ensure that final themes were an accurate representation of the whole data set (Smith et al., 2009).

Table 2.2: The Analysis Process (Based upon Smith et al., 2009)

Table 2.3 Credibility of analysis: auditing the process

Stage	Audit Process	Amendment made
First level of analysis for first two interviews	Analysis checked by clinical supervisor	Less time taken to write the initial noting in an attempt to focus more upon the emerging themes and move away from the detail of the data.
Emergent themes of all interviews	Briefly checked by a university tutor experienced in qualitative methodology	
First level analysis of all interviews	4 pages of each interview reviewed thoroughly by a university peer, familiar with IPA	Emergent themes were thought to be an accurate reflection of the data. Some more interpretative aspects of analysis were suggested and discussed. These informed the development of individual superordinate themes.
Establishing final superordinate themes	Time spent with clinical supervisor to select and arrange important themes. Discussion around recurrent patterns and how to balance descriptive and interpretative analysis.	Broad themes were established together. Researcher then worked on these further and created the final overarching superordinate themes.

2.5 Results

Analysis of the interviews using IPA established three overarching themes, 'Control', 'Process' and 'Congruence'. These and their associated subthemes were present in at least half of the sample (Smith et al., 2009; Table 2.4). The themes will be summarised and then elaborated upon further with the use of illustrative extracts.

The first superordinate theme 'Control' was an important theme across the data set and identified both at an explicit and an interpretative level of analysis. Participants shared their fears around working with coercive powers; this became a subtheme and included discussion around the responsibility of working with powers of restriction. The second subtheme outlines some of the benefits of CTOs and is entitled 'Benefits of structure and boundaries'. The final subtheme under control concerns 'managing the therapeutic relationship' and outlines the way in which the CTO can impact upon it.

The second superordinate theme, 'Managing the Process' is concerned with participants' evaluative accounts of the practical application of the CTO. Three key themes emerged from this area and are explored under the subthemes of 'Effectiveness of CTO', 'Collaborative Team Working' and 'Competence: of self and others'.

The final theme of ‘Congruence’ is more interpretative in nature and arises from a perceived experience of conflict whilst working with the CTO. It can be summarised under the subthemes of ‘integrating models’ and ‘updating ideology’.

Table 2.4 Superordinate Themes and Subthemes

Superordinate Themes	**Subthemes**	**Present in at least half the sample?**
Control	Risks and fears of working with coercive powers	Yes
	Benefits of structure and boundaries	Yes
	Managing the therapeutic relationship	Yes
Managing the Process	Effectiveness of CTO	Yes
	Collaborative team working	Yes
	Competence: of self and others	Yes
Congruence	Integrating models	Yes
	Updating ideology	Yes

2.5.1 Superordinate Theme 1: Issues around Control

Each of the participants spoke about issues relating to control, including their experiences of working with coercive powers and the impact that they perceived this had upon their therapeutic relationship with clients.

2.5.1.1 Risks and Fears of Working with Coercive Powers

Participants described their awareness of the extent of the powers inherent in a CTO and their perception of its significant restrictiveness. Participants spoke about being mindful in using the powers judiciously and acknowledged ethical concerns. Heather talked about the CTO as being "*more police-statewise*" (line 112). Sam described the potential of the CTO to act as a "*hooded threat above the client*" (line 852) and James shared concerns that the order could be deemed as more intrusive than a hospital admission.

"It's not associated with an institution, and it's not associated with I guess what may seem like a more fixed period of time... whereas, if it's there when you're at home, going about your life as you usually are, then it's much more invasive." (James, lines 452-459)

Participants also shared concerns around the potential for the CTO to be overused, perhaps as a shortcut to engagement or to manage risk more easily. Many of these fears were in fact not thought to have materialised so far in the service, but remained prominent in their narrative.

"If it's used as a means to free up beds in hospital... if you like continuing the formality of the section in the community, it shouldn't be used like that... Either you need to be in hospital or you don't." (Sam, lines 914-922)

Two participants also described concerns that the CTO could be used punitively by staff who were struggling to engage clients with more complex needs.

"When we deal with a difficult client, and particularly if you're looking at some personality issues... they are hard work, manipulative and any, you know, client group that's manipulative, there is the temptation that it can become a little bit personal, even with professionals." (Heather, lines 470-476)

Concerns were raised about the wider impact of being under the legislation including issues such as employability and potential to travel abroad. A further anxiety was the idea that the CTO could make clinicians 'lazy' in their care for clients.

"It [the CTO] can make you lazy in terms of ... you don't necessarily have to go down the route of being as flexible as possible." (David, lines 97-100)

"The power balance has shifted very much towards the nurses: 'if you don't have this off me, I'm telling the doctor that you haven't had it and, you're looking at recall'. It's- it's a very powerful situation to be in (Jane, lines 173-180).

David went on to discuss the balance between managing and increasing risk.

"The downside, and what my big concern is if you've got someone who really is in a very stuck situation, if you're forcing them to do something in a long term way, you're forcing them to do something that could make them feel more and more hopeless and you could drive them to suicide." (David, lines 324-339)

2.5.1.2 Benefits of Structures and Boundaries

Each participant communicated the sense of individuality involved in the CTO, both in terms of its application and clients' responses to it. There were benefits discussed,

relating to staff and clients and these revolved around the use of boundaries and structure.

"They seem to find something reassuring and containing about a structure, I wonder sometimes with some people if it's also about... the acceptance of their mental health problems in some way. It's almost kind of like "I know I've got a problem but I don't personally want to recognise it, but I know I don't like taking medication but I know that it keeps me well. If it's imposed by somebody else, I could almost stand back from it and accept the problems I have in my own way and tolerate and accept the medication, but I don't feel like I have to own that decision to take it." (Diane, lines 29-41)

Heather talked about the way clients who had a personality disorder may "*struggle with boundaries*" (lines 12-13). She returned to this point later in the interview:

"You know, if they're difficult to work with and they can't have their own boundaries, sometimes to create some boundaries for them actually makes them feel quite safe" (lines 786-789).

Jane described the increase in clients with personality issues being seen by the team since the changes in the Mental Health Act (lines 617-618) and described the CTO as being "*in some ways [it] can be another boundary that's very very clear and very easy to work against, but again, with people with personality disorders, they're really going to push against it*" (lines 626-630).

The impact of personality issues was discussed as one possible variable to accepting compulsive powers; this was evaluated by David:

"I suppose it does sort of go against the grain really about how you approach someone with personality disorder because I think it's in virtually all cases, it's key that the person takes responsibility for their own actions and to actually do

something where you're compelling them to, you know, do particular things, then that could be potentially harmful because they're not able to then take responsibility. On the other hand, when someone is so chaotic and so, things are so difficult and there's psychosis involved as well, then sometimes you need to put in boundaries which they could then find helpful" (David, lines 9-10).

Cohort effects were also mentioned by a number of participants in relation to the idea that some clients tend not to question the advice of a medic, and so for those people compliance may occur more easily.

"Some people can be quite old school and 'the medic is right'... we've got some people that say "I've been told to by the doctor therefore I must"- and were they on discharge before without the CTO they probably would take the medication for a few months, 'because they'd been told to by the doctor' then they would start dropping it down. We'll go back and say 'look- Dr X says you need to take these, he's written it out on the CTO and you need to continue don't you?" and he'll be like "yeah I do, don't I" and carry on." (Jane, lines 672-684)

Other participants suggested that past experience of other services and experiences of previous relationships may influence how a client responds to the control of a CTO. Diane talked about this in relation to attachment style:

"I think it's about your relationship between the client and the worker and that's hugely biased by, kind of early experiences and attachment styles and possibly kind of some, kind of elements of recovery and insight styles" (Jane, lines 908-913).

For staff boundaries also appeared to be important. Information was said to be logged more clearly as a result of the CTO, and there were policies which could be followed in a structured way to 'protect staff' in their decision making. James described how CTO structure could make the work of staff easier:

"I think for some people, there's, it kind of works post discharge because it has, it has a structure similar to the kind of, some of the structure of the hospital that can give us clinicians a better chance of getting in to see people and making sure the treatment's going as it should do" (James, lines 385-390). He later described how the recall process had "*definitely less stress and anxiety for staff*" because of its "*explicit and clear*" nature (James, lines 721-725).

Whilst benefits to staff were acknowledged, the idea that staff were also *coerced* by the CTO arose.

"I think, they seemed really heavy handed and I think part of the concern is that they, they do, once they're there as legislation, once they're there as an option, it can feel like it forces your hand a bit, because in the past where you've been able to take decisions because that's not even there as an option you've got to be able to satisfy that it, it shouldn't be used, and it's kind of almost looking at it the other way round, rather than looking at 'what are the options we've got?'" (James, lines 267-278).

"But I think it's quite clearly about, you know, "what would happen if something happened? How would that be reviewed? What would the questions be? And I think sometimes we feel the questions would be "why haven't you know, if that person's risk is linked to their mental health and their mental health is linked to their acceptance of their medication... why haven't you done something about it?" (Diane, lines 144-152)

2.5.1.3 Managing the Therapeutic Relationship

The impact of the CTO upon the therapeutic relationship was a significant theme. Participants shared their experience of how, for many, the introduction of this legislation made it difficult for clients to engage.

"He concentrates on the fact, which is understandable, that we have some power over him and I think that makes him very angry which then he doesn't want to have really anything helpful from us." (Katherine, Lines 499-503)

Sam too described how the CTO dominated his interaction with some clients:

"It's almost like that discussion around the injection's... always in the fore now and it feels like you just can't engage him in any other way. Like you know, you'll say "look, OK, let's not focus on that now, can we, you know, how are things in other areas in your life?" That has become a real stumbling block ...and it's just destroying to see somebody in that much distress and he blames it all on the fact that he believes his locus of control has been taken away. And with a CTO that's the bottom line; if you remove that locus of control away from anybody they then feel like a lot of their existence and their life choices are not their own." (Sam, lines 236-259)

Jane described her attempts at managing the two sides of responsibility that this interaction brings in the context of the review:

"I'm very conscious that you make it a positive, like you're feeding back the positives as well as the negatives and that side of things with somebody. And it can be quite difficult getting the right balance with it, because you can sit there and be quite dictatorial and "you did this and this and this" and it's much more important that you're getting the right outcome at the end, but that you're, you're still able to

work with the client after as well. It's a tricky balance some days." (Jane, lines 765-774)

The following extracts outline the tension between the costs and benefits of implementing a CTO.

"Often with these people, 'cause they feel forced into seeing you they don't, they're not as open at talking about kind of their lives and other things that are going on because it almost feels that barrier is there as soon as you walk in: "I've been told I've got to see you." (Diane, lines 282-287)

"If his CTO was lifted, he would definitely stop the medication, he'd be mentally unwell again, he'd be in hospital, so there's a real sort of dilemma there because he wouldn't be able to get on with his life either, if he's mentally unwell and because of the CTO he won't accept any help." (Katherine, lines 519-525)

Chloe however described her work with a client whose anger towards the CTO impeded his recovery by becoming the dominate focus of their interactions.

"A couple of years down the line he started to really start challenging his medication and the boundaries of the CTO. And it just became really difficult for me. Everytime I went to see him, that would be the focus of the discussion: challenge, challenge, challenge. "I'm going to kill myself" I can't- you know, "with this medication I might as well be dead, "just send me to hospital now because I don't want to take it and I might as well be drugged up in hospital because I have no quality of life whilst I'm on this medication... Everything that was wrong in his life was due to his medication and that was something he saw our team as imposing on him through the CTO." (Chloe, lines 155-177)

2.5.2 Superordinate Theme 2: Managing the Process

The second theme of 'Managing the Process' explores issues relating to the practical implementation of the CTO and participants' experiences of working with the legislation.

2.5.2.1 Effectiveness of CTO

Participants spoke in an evaluative way about the use of the CTO. Despite reservations around the impact upon the therapeutic relationship all participants identified certain positive attributes. They also shared their surprise at the significant number of clients being content on a CTO. Estimates ranged from between 25-60% of the CTO population feeling settled. Key 'process' benefits of the CTO included a simplification in the admission process for those who had relapsed and an improvement in monitoring those in the community.

Jane described how the use of the recall powers of the CTO allow the team to communicate to clients that they can keep them safe when needed whilst also encouraging a swifter recovery than may have otherwise happened.

"Other recalls have worked where we've had people in, briefly, they've restarted either the depot or the oral medication and they have gone back out again. And it does seem to have worked, it's been... it's shown... it's sort of evidenced to the client that, it, we can use it, but also that you're not going to be in for the next 10 months and you're going to be back out to be able to move on with things, so that's positive as well I think, that you can turn things around quite quickly." (Jane, lines 355-364)

This coincides with the idea that was shared by many around the length of time that an assessment can take when someone's mental health deteriorates; Heather outlined her concerns on this:

"I've seen clients left in a very neglected state for a long time, longer than they should have been, you know. And I mean when this CTO was in place, this person had been in hospital 18 months and I said "I'm not leaving, you're not going to be left for months and months in the state that you was before, because it's not fair and no human being... that's one of the reasons it was brought in" (Heather, Lines 591-598)

Heather also experienced the way it saved on the "trauma and logistics" of a mental health assessment (Lines 8-9), a view echoed by James, who felt that the recall process was simpler than it would previously have been. He went on to describe his frustration around waiting for the police in either instance (Lines 710-712). The CTO was also thought to offer clients and their families a greater confidence in accessibility to care.

"*Once there was a CTO in place it gave them both [client and partner] some reassurance that they would be able to seek help more easily in a way*." (Chloe, lines 99-102)

James also described how the CTO formalises the monitoring process in a way which in fact aided engagement.

"I think it has provided some clients with longer term stability and treatment. It's also provided them with longer term engagement, people who normally we'd lose track of or lose sight of, we wouldn't see for a couple of weeks at a time, have to try and make judgements... there's one lady who we work with who's- one of the conditions is that we see her twice a week and I've been amazed how well that's gone" (James, lines 752-760).

Outcome measurement was also discussed; two participants shared concerns around the lack of an evidence base in this country. David suggested certain outcomes for monitoring success; they included [hospital] 'bed days', quality of life measures,

employment outcomes and reported levels of satisfaction (page 24). Sam explained the difficulty in detecting *which* part of an outcome was attributable to the CTO and which to other parts of the intervention.

"...I can see improvements and... are people improving because of the CTO or are they genuinely improving to the point where they've moved on in their life?" (Sam, lines 419-427)

Jane shared a similar conflict around justifying the use of the CTO to others:

"It can be a little bit more difficult to actually sort of justify why this person needs to stay on a CTO... It's quite easy to justify once someone's in hospital. Once someone's out and he's been 6 months taking their medication everyday and joining in, following the terms of their CTO, it's very difficult to say "ah well, they're only doing that because we've told them to do that, they wouldn't do that of their own accord." Because the client will cheerfully sit there "yes I would, look I have done, what's the difference?" (Jane, lines 457-472)

2.5.2.2 Collaborative Team Working

The process of CTOs was also discussed in light of the collaborative ethos of the team. References were made to trusting the consultant at a personal level, and how important the personality of team members was in implementing this legislation. Team discussion was found to be a key aspect in the decision making process.

"We've done quite a lot of coming back to the team, looking at in supervision and looking at how we feel about it and how we can take it forward. And done quite a lot of 'is this the right thing?' Like some of the depots have horrible side effects and things as well, there's, there's quite a lot of them you wouldn't want to take yourself, so yeah... (giggles) why the hell should the clients take them? But we're... it's been a

very supportive process: we've come back, we've talked about it, you've felt very reassured that yes, this is the right thing for them." (Jane, lines 189-200)

Structured and informal supervision were also identified as being processes which aided the collaborative nature of the team, and Sam discussed how this had developed as an unintentional response to the CTO.

"But one thing that we factor in now, we've done that through a case of stumbling over it and just listening to each other and trying to, we've brought in a lot more supervision- ...things like having- on a Monday morning ... everybody has an opportunity to put a name up on the board of a client they'd like to discuss on a Monday morning. So we found that a lot of the people who were having problems with the CTO were on that list." (Sam, lines 614-624)

Collaboration seems to allow shared responsibility for the decisions, and in fact the process of working through various perspectives within the team appears to play an important role in protecting the process.

"There's usually somebody in the team at that point playing devil's advocate and it varies, ... but there's always someone in the team that would go 'what happens if we'- so say the prevailing view is we stick, we put them on a CTO, there's always somebody in the team 'what happens if we don't?'" (Diane, lines 455-461)

The use of such collaboration was considered in relation to the need to engage at an individual level due to the wide variation in client responses to the CTO. This flexibility was felt to be a strength of the team, stemming from their skills in working assertively. Other collaborative process issues were also reflected upon; they included swapping team members around to support clients and sharing 'difficult' visits with colleagues.

2.5.2.3 Competence: of Self and Others

Participants communicated their experiences of training and the learning that had been undertaken since the introduction of the CTO. One participant described a keen attention to the detail of the legislation, while another shared fears around their competence to implement some aspects of the process. Common to all was a perceived need to communicate an essentially good understanding and a level of skill in the interviews. This could be interpreted as relating to anxiety around 'getting it right', which was felt to be particularly important given the controversial nature of the powers.

"...I still feel a little bit unsure about some of the stages and responsibilities. I kind of know what I need to do- but I would probably struggle if I was being asked to arrange transport and all those things... that would cause me a bit of anxiety. I think there probably is a bit of anxiety about what would happen if- at a weekend when you're on your own you need to recall somebody." (Chloe, lines 529-541)

James expressed anxiety around the heightened level of responsibility associated with the CTO, commenting how his work had previously involved admitting people, not discharging them.

"...If we're coming up to a planned discharge day with the idea of a CTO I'll ask our Thursday planning meeting, I'll kind of present some thoughts, ask people to go away and think about it and ask that we timetable in discussion for the next Monday so that we're- because we do need to make the decision as a team and people also need time to reflect on what they think is- I think it's important that we make the decision slowly and we don't kind of, the decision isn't made when we're rushed and busy..." (James, lines 580-595)

The confusion of staff over terminology relating to the CTO was a recurrent topic, as well as the idea that certain staff receive more thorough training than others.

"...The lacking training was actually around the framework, yes there was training days we went to, but it's not real, it's just 'well this is the flow chart and how it works'. ...even though percentage-wise we're the highest proportion of staff in any service as a nurse, you actually do feel sometimes that, well you're seen as the work horse, as a person that's actually got to do it. So if I go to you and I'm really not sharp on what a CTO is ... then I get to be represented by the client as the negative side of the CTO..." (Sam, lines 556-571)

The competence of other services was also alluded to by a few. The idea of using CTOs in the context of a Community Mental Health Team (CMHT) setting was mentioned as an issue of concern by many, because of the perception that they would be less well resourced to work assertively alongside the powers of the legislation. A lack of training in mental health and understanding of the CTO was also attributed to solicitors in their work at tribunal and to police in their response to clients in crisis.

2.5.3 Superordinate Theme 3: Congruence

The theme of congruence is more interpretative in nature and emerges from the data that highlights the conflict participants felt following the introduction of CTOs. This can be thought about from the perspective of the *models* used within the team, and at a more '*ideological'* level, where attitudes have been challenged and altered through the process of implementing CTOs.

2.5.3.1 Integrating Models

Participants shared their perspective that medication was often helpful for the clients they worked with. Alongside this however, was the sense that medication alone was

insufficient. David reflected upon the balance required between ensuring engagement and enabling recovery:

"It's against the ethos of Assertive Outreach in many ways, because you know, our focus of engagement with people on, not necessarily inflicting a medical model on them, on recovery model and someone's abilities to make choices about the way in which they sort of, the journey of recovery they take... But actually, Assertive Outreach has always involved, you know, detaining people against their will and at times when they're really unwell. So in some respect you could argue that that's nothing new" (David, lines 76-89).

This engendered mixed feelings about the place of the CTO alongside the provision of holistic care. Whilst some criticised the CTO for being 'overly medical' in the way that it focused only on medication compliance, there was simultaneous consensus that the involvement of psychosocial treatments as part of compulsory criteria was inappropriate.

"I haven't yet come across a situation where it's going to be beneficial to, you know actually force someone to go to OT [occupational therapy] sessions, or a therapeutic group or whatever it is, because I think you have to let someone make that decision. So that's one thing- I think even if you did put that in place you'd then have to say "ok, are we prepared to recall someone to hospital because they didn't go to their therapeutic group?" (David, lines 737-751).

Participants shared their experiences of criteria in a way which suggested the use of stipulations beyond the standard issues of where a client must live and what type of medication a client should take, remained unresolved. There was a consensus that although value could be seen in implementing these models, they may not fit with a compulsory way of working.

"We've made definite decisions not to include- although we thought it might be a good idea- we've not included conditions that you engage with a drugs worker or anything like that, or abstinence... But yeah, I think we've tried to be a bit more sensible with those things. Because I think if you're forcing someone into a therapeutic, you know, trying to force someone to engage in BFT [Behavioural Family Therapy] seems a bit counterintuitive, you need to have a bit of volition to do it themselves in order to change." (James, lines 811-822).

Participants had clearly stated that being on a CTO did not restrict a client's access to any of the other therapeutic treatments offered by the team. Despite this, it was suggested that the emphasis of the CTO to medication may divert the focus back to 'the illness', and essentially be insufficient.

"I think just putting someone on a CTO with medication is erm a little shortsighted, I think if the person is going on a CTO for their improvement, or for their safety, then I think something else should be offered as well, like a course maybe they'd be interested in, computer, home studies... something to really help that person recover." (Katherine, lines 629- 636)

Several participants suggested that the CTO had introduced a new dynamic to the therapeutic relationship and Chloe described in more detail the tension that this could place upon her usual way of working.

"I think it's a difficult one, because you do, you know, I'm an O.T. but I am a care co-ordinator and we work as a team, so it's kind of, I do feel sometimes I can't be too precious about what I will and won't be involved in. And I do see the role for medication and I think in some cases it's very difficult to get therapeutic gains without medication, and often it is a stepping stone for OT and further work for the

person to be treated properly with medication in the first place." (Chloe, lines 891-903)

Finally, whilst all participants overtly acknowledged the value of working holistically, there was perhaps an underlying feeling from some that medication formed 'the treatment' with other, arguably less realistic, therapeutic models being added on. Here Heather responded to a question about where she would prioritise extra resources.

"There's... all kinds of issues that have gone on in childhood that we never, you know, we never really speak about, we never really ask to be fair... Probably because the resources isn't there, you know, to mop up the spillage, do you know what I mean type thing? If someone did spill their guts out, you know." (Heather, lines 706-721)

"I mean it depends on the individual and risk stuff, doesn't it? Because it's all right this psycho-babble, but if someone's risky, then you've gotta protect public and themselves." (Heather, lines 273-277)

2.5.3.2 Updating Ideology

Participants all shared their experience of adjusting to the CTO and of the way their attitude towards it had changed as they observed the benefits to clients.

"I think it's easier now, having known the quality it can produce. Whereas before they were talking about putting somebody on the CTO who I was totally, totally against. I thought that would be the worst thing that you could do for this person and in fact it's worked out really well." (Katherine, lines 413-420)

"I must admit when I first saw it I thought "this is really intrusive"- I'm not one of these dogmatic, snatch their liberty away and all that type personality, do you know

what I mean? But as it's happened, in practice it works fairly well." (Heather, lines 565-570)

"I think we've all kind of changed our opinions as time's gone on and I think there's definitely been learning for us. I think we've been surprised by some of our clients who've asked to go on a CTO which seems kind of immediately counterintuitive. But I think that's good and I think that's kind of helped with the learning about it." (James, lines 671-678)

For each of the participants, their attitude to compulsion had developed as a result of their experiences. This process however appears to have been easier for some than others as the following contrasting quotations highlight.

"So yeah, it is, it is incredibly- it's an incredibly stressful way to work I think. The assumption is to think 'well it's such a negative impact on a client' and in terms of your role as a practitioner, you've always been trained you've got autonomy in your decision making it is asking very very, it can be very stressful to actually start thinking I really really ideologically don't want to do this, but I've got to." (Sam, lines 825-833)

"I think people are quite comfortable using them as well now, so people feel that they, they know what they're going to be saying to the client about them and I think that people are more comfortable with that now." (Jane, lines 435-440)

Finally, Katherine's comments point to her discomfort around being associated with what she describes as a 'regime' and suggest a conflict between her recently developed perception that they can be helpful and her lingering fear that they are not.

"I think there's- I say scaremongering because that is in the public- it's this "oh you know what happens, if they- if you don't take your medication, they'll put you on an order and they'll throw you in hospital if you don't take it' and it's like so archaic,

and I'm trying to say err "it doesn't work like that' you know, there's a lot of thought that goes into it, there's a lot of reasons why, and risks have to be consideration and... and they go 'well you would say that, you're part of them' if they're angry.. you go along with it because you're part of that regime and it's like (high pitched voice) "oh my gawd no!" (Katherine, lines 925-939)

2.6 Discussion

This study was interested in the subjective experiences of clinicians working with CTOs. It explored the impact of the CTO on professional role and practical implications at work as well as the perceived usefulness of the CTO and its effect upon the client. Eight interviews were conducted with multidisciplinary members of an Assertive Outreach service. IPA analysis established three superordinate themes emerged from the interviews: 'Control', 'Managing the process' and 'Congruence'. The findings will now be explored in the context of the literature and will be discussed under their respective research aims. Due to the inextricable nature of some of the issues covered, there may be some overlap between these two categories.

2.6.1 What are clinicians' experiences of working with CTO?

This area consisted of questions on its perceived usefulness, the practical processes involved and its impact on the professional role. The themes arising from this aim include 'risks and fears of working with coercive powers', 'collaborative team working', 'competence' and the superordinate theme of 'congruence'.

Participants' attitudes towards the CTO seemed to have changed since the legislation had been implemented suggesting that many of their initial concerns had not materialised in the way that was feared. It is a finding which is consistent with other research (Manning et al., 2011) and suggests that the implementation of this form of care triggered staff to update their previously held views on coercive treatment and

integrate them with their experiences. Each participant shared their surprise that some clients elected compulsion by choosing to be under a CTO. This is an interesting concept, given that AOTs tend to work with clients who are at risk of disengagement and experiencing symptoms which may reduce their awareness. The idea then that someone may choose a measure which compels them, perhaps demonstrates an acknowledgement that their awareness may change over time. Diane seemed to suggest that clients who defer responsibility for their care do so as a way of protecting themselves from distress related to an increased awareness of their illness. This would imply that accepting treatment holds with it a risk that the illness itself must be accepted, which for some is very difficult. Coercive care is often considered most helpful with those who are not aware they require it (Kerstin, 2002) and yet the findings of this current study suggest otherwise.

All participants described how collaborative multidisciplinary working was key to the effectiveness of managing clients on CTOs. At the same time, some participants reported experiencing tension between their professional identity and their required participation in the enforcement of the CTO. For example Chloe acknowledged that medication could *enable* further work to be effective and so actively participated in encouraging compliance, whilst also expressing a concern that her commitment in the medical model did not become so great it subsumed her other professional contributions. Thus a balance of 'investment' is required both at an individual and team level when working in a holistic way. Participants seemed to share an understanding that medication could offer significant benefits to clients, but that medication alone was insufficient in treating the difficulties that this client group

experience. The CTO focuses the attention of staff and clients upon the administration of medication and this was one of the difficulties discussed. The place of other interventions such as sports groups or behavioural family therapy, whilst viewed as valuable, seemed to have less of a clear role in the treatment plan for clients who were on CTOs. Participants were uncomfortable with the idea of enforcing treatments other than medication and seemed to question the value of it.

Staff anxiety around the process of the CTO was apparent in many of the interviews. One participant shared concern around being less knowledgeable than colleagues who had received more training, while another participant who had received that training shared their anxiety over the increased level of responsibility CTOs create. Someone else expressed a feeling of vulnerability, as a result of being at the 'frontline' of delivering care whilst not being entirely aware of the process. Whilst the team were familiar with managing risk, their own concerns around the use of coercion, combined with the perceived complexity of the legislation seemed to have triggered a strong desire to avoid making mistakes.

Some participants felt that further planning on ending CTOs was required within the team. There was also a discrepancy in how many people were thought to have had their CTO removed. This is possibly attributable to the apparent sense of confusion in the team around particular practical aspects of the CTO and to the relative newness of the legislation. It could also reflect a lack of clarity in the guidelines around indicators for the removal of CTO.

Participants shared their experiences of CTOs in a way which was informed by their own education, professional background and personal values, each from a different perspective. Staff attitudes to coercion are thought to be influenced by personality and values (Husum, Finset and Ruud, 2008; Husum, Lossius, Johan, Finset and Ruud, 2011). Participants demonstrated a degree of tension between the use of coercion and engagement. It is possible that staff who work in an Assertive Outreach service are likely to have a heightened awareness of issues which may impact engagement. This current study identified that staff anxiety was a prominent factor in the use of CTOs and that associated difficulties in the therapeutic relationship were a source of anxiety. One participant who shared their need to have time away from their client also shared their significant anxiety about the process. It would be interesting to consider the anxiety caused by CTOs further given the research suggesting that lower staff anxiety is associated with positive therapeutic relationships (Berry et al., 2008).

2.6.2 What Impact does a CTO have on a Client?

This question related to issues of risk, engagement, relapse and access to broader support. Whilst aspects of this question relate to each of the subthemes established, the main two are 'benefits of structure and boundaries' and 'effectiveness of CTO'. When discussing staff's perception of the impact of CTOs upon the client it became apparent that participants shared many of the concerns identified in the literature. Most mentioned a fear that CTOs would be overused, a risk identified before they were introduced (Mind, 2007). Participants' anxiety around the removal of control from clients mirrored previously identified claims that the CTO had the potential to

generate ‘disempowerment and stigma’ (Brophy and Ring, 2004). At the same time, participants identified some of the benefits that had been reported in the literature. Jane’s description of how helpful the CTO had been in preventing a significant relapse by offering the client a short hospital stay, fits with findings that an association could be made between the CTO and a reduction in long hospital admissions (Kisely et al., 2006). The findings of research carried out in New Zealand also concludes that overall, the costs of the legislation are outweighed by the benefits (Gibbs et al., 2005). This was supported in the present study by participants who spoke positively about many aspects of the powers, including increased monitoring and reduced relapse outcomes which signify the success of the CTO in those cases (Department of Health, 2008; Gray and O’Reilly, 2005).

Participants described the variation in client responses to the CTO. Variables such as personality difficulties, previous negative experiences of services and attachment styles were all identified as influences. This is valuable information given the rising number of clients seen by AOT with a personality disorder diagnosis, following the changes in the mental health act. Research has found ‘attachment avoidance’ in clients to be a factor influencing poor therapeutic relationships (Berry, Barrowclough and Wearden, 2008) as well as poorer personal relationships and a less integrative recovery style (Berry, Barrowclough and Wearden, 2007). This suggests that attachment style could play an important role in the way that clients engage with staff and consequently how staff experience the effectiveness of the CTO.

David expressed concerns that to restrict clients too much could unintentionally *increase* their level of risk. It seems that such an issue may be overlooked by the legislation and so managed at the discretion of the team. The sensitivity and reflexivity of the clinicians is therefore paramount. One longitudinal study found that an external locus of control was significantly correlated with fewer periods of recovery, low mood, psychosis *and* to various aspects of personality (Harrow, Hansford and Astrachan-Fletcher, 2009). This would imply that the less involved the client feels in their care, the greater their risk of mental ill health would be.

The issue of how control is maintained and who takes responsibility for such control was prominent throughout the data. The clients who seemed to be experienced as most challenging to the staff were those who resisted care. It could perhaps be interpreted that in a system where clients feel control has been withdrawn from them, their repertoire of communicating distress is limited. Therefore the expression of anger might manifest instead as non compliance; this serves to allow the client an element of control over others whilst also eliciting control from others. This process is similar to that of a child with a disorganized attachment style (Main and Solomon, 1986); where the client is left feeling powerful (because whilst in control they are safe) but at the same time powerless (because control alone does not offer what is needed).

This study demonstrates that staff experiences of clients' responses to the CTO were varied and recognises that staff have responded to the legislation by developing their

ideas about compulsory community treatment. The CTO continues to be viewed with caution in the team, but is associated with benefits for many clients.

2.6.3 Methodological Considerations

2.6.3.1 Choice of Methodology

The results generated by this research suggest that staff are interested in reflecting on the way that CTOs have impacted upon them. Whilst use of the CTO has been audited in different places in the UK, there are no known studies examining staff experience of the legislation. It was important therefore to use a qualitative method. IPA was deemed most appropriate because of its commitment to capturing individual experience, this was important given the variety of perspectives expected in this multidisciplinary sample. Yardley's principles for assessing qualitative research were followed in order to ensure the quality of the research (Yardley, 2000).

2.6.3.2 Methodological Limitations

There are a number of methodological limitations which should be reflected upon. Firstly, recruitment was organised through the researcher's clinical supervisor who was based within the team that supplied most of the participants. Despite reasonable attempts to mediate this pressure, it is possible that some participants felt obliged to be involved and were more cautious about sharing their views in an open way.

The second potential issue when conducting research with a staff group is the dynamic introduced by being interviewed by someone also working in mental health. A sense of shared understanding may have helped to put participants at their ease, but also may have increased anxiety about how accounts were being interpreted. Participants were asked to share a more 'vulnerable' side of themselves whilst at work; it is difficult to know to what extent narratives were edited in order to maintain professionalism.

The third main limitation of this study relates to the inexperience of the researcher in conducting research interviews and adopting an IPA analysis. During transcribing it became apparent that some questions had been asked in a leading way despite a conscious effort to use open ended questioning. Fortunately when this occurred participants were usually confident in either correcting or confirming the assumptions that were implicit in the question. It is likely that the quality of interviews improved as they progressed.

The research aimed to gain a general understanding of staff experiences of CTOs in an AOT. This is a broad area to cover and whilst a significant amount of information was obtained, some of the issues raised would have benefitted from further exploration.

Finally, it should be remembered that whilst this research has achieved its aim of exploring AOT staff experiences, such findings cannot be generalised to a wider

population. On a related theme, by interviewing staff about the experience of another, an added layer of hermeneutic was introduced; therefore data relating to clients experiences can only be considered a reflection of participants' perception, and does not provide direct access to the experiences of the clients themselves.

2.6.4 Implications for Clinical Practice

This study's findings generate several implications to support the experience of staff using CTOs in an Assertive Outreach service.

1) The issue of staff competence and training arose, specifically an apparent discrepancy in training across the different disciplines. Whilst it was acknowledged that some team members required a more technical level of knowledge, some participants felt that they were not as skilled as they would like to be. This would suggest that training on the basic process of the CTO should be regularly revised and updated.

2) The importance of collaborative working was also identified as being a key factor in working with clients on CTOs. The team had been proactive in developing structured peer supervision and regular whole team discussions, activities which could be replicated in other settings. The provision of sound clinical supervision is particularly important given the links found between staff attachment style and therapeutic relationships (Berry et al., 2008).

3) The way that the CTO is ended also emerged as an area requiring further thought. Experience of clients having their CTOs removed was minimal, which could be expected given the relatively recent introduction of such legislation.

Despite this the CTO guidance seems to lack clear protocol on identifying when a client can be judged as ready to move beyond the powers. It would be useful to develop a formal document to consider this approach further in order to structure the process in a transparent way (Lawton-Smith et al., 2008). The ongoing impact of the CTO could be reviewed through the use of routine measures such as 'bed days' and levels of client engagement.

2.6.5 Recommendations for Further Research

There remain wide gaps in the evidence base for the effectiveness of CTOs, and to date there is no known research into clients' in the UK experiences of being on a CTO whilst on an AOT caseload. These concerns appeared in the data and are key issues which require further research. The area would also benefit from greater research into the variables which impact upon clients' engagement with CTOs; this may help to predict which clients will benefit most from compulsory community treatment and identify ways in which this treatment can be used best. Such research could be informed by literature on attachment theory and recovery styles.

In light of this study's findings around the way in which attitudes of staff have been challenged and altered, future studies could examine the impact of staff attitudes to compulsory treatment upon the therapeutic relationship. This is a particularly important area given the subjective, negotiable and 'creative' way in which the CTO is implemented as it is staff who mediate the delivery of it (Dawson, 2007).

The process of the decision making around the CTO was found to be important to staff members in managing the responsibility involved and included subjective qualities such as ‘trusting the psychiatrist’. Further research could seek to gain specific information on a wider scale in an attempt to define the helpful and less helpful aspects of this process. Training delivered to staff groups could also be evaluated in order to ensure that it is meeting the needs of its recipients; this is particularly important given the complex nature of the legal aspects of the legislation and the anxiety involved around managing risk.

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Chapter Three: Reflective Paper

Conducting Empirical Research: Reflections on Control, Process and Congruence

This paper has been prepared for submission to PsyPAG Quarterly.

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3.1 Introduction

This paper offers a reflective account of conducting empirical research regarding an Assertive Outreach Team's (AOT) attitudes towards Community Treatment Orders (CTOs; Department of Health, 2008). Eight staff members were interviewed regarding their experiences of using CTOs. Interview recordings were transcribed and analysed using Interpretative Phenomenological Analysis (IPA). Throughout the research a reflective journal was written. On reviewing the entries I have been struck by how closely many of the issues I have encountered map onto those shared by the participants. Consequently my reflective account will be structured around the three superordinate themes which emerged from the empirical data.

3.2 Managing the Process

The theme of 'managing the process' in my empirical research was concerned with participants' evaluative accounts of the application of the CTO and covered issues such as its effectiveness, the use of collaboration and self competence. My experience of managing the process of research will now be explored with reference to methodological limitations and reflections on CTOs.

3.2.1 Methodological Limitations

The participants used in my study were recruited from a service within which my clinical supervisor worked, consequently some staff may have felt a pressure to be involved and may have been guarded about sharing their experiences. Such risks were reduced by the study's design; for example no raw data was shared with that

supervisor. Despite this, it became apparent that some participants may have been anxious about their involvement with one likening the interview experience with 'going over the trenches'. Most participants were enthusiastic about participating however, with some stressing the importance of such research.

My own limited experience of interviewing should be considered. The process involved a steep learning curve which is likely to mean the interview quality progressed with each participant. Whilst I am familiar with the use of active listening skills, having a range of key topics to cover in such a limited time increased the demand for thinking 'one step ahead'. Consequently I found myself asking long or leading questions and found that seeking clarification from participants was important in managing this. In future I would use a shorter interview schedule. I would also use discussions with staff to develop the schedule, because on reflection they would have offered useful ideas around the issues important to them.

IPA is a qualitative method which focuses upon describing the meanings attributed by people to their experience (Smith, 1996). It is *phenomenological* in the sense that it relates to how one *perceives* the world and *interpretative* because of its reliance upon the researchers *own experience* in attempting to make sense of that experience. My experience of using IPA was generally positive. There were moments however during which I became overwhelmed by the detail required by the line by line analysis of transcripts (Shinebourne, 2011) and the amount of data generated. I also struggled at times to balance the use of descriptive and interpretative analysis, a trait

which is thought to characterise the novice (Smith, Flowers and Larkin, 2009, p.103). I became seduced into generating further questions as I analysed the data and was frustrated by the lack of reciprocity involved in working with 'one off' accounts. As my experience with IPA developed however, so too did confidence in my role as a 'filter'. During those times it was helpful to regularly refer to my research aims in order to focus my attention (Gee, 2011). It was challenging to write meaningfully about all eight interviews and I was required to be highly selective when constructing the final report, condensing over 1000 themes into 3 final key concepts. Such reduction of the data required a rigorous determination which also triggered anxiety relating to my desire to capture its essence. Frequent consultation with my supervision team was important throughout this process.

3.2.2 Reflections on Community Treatment Orders (CTOs)

Having never worked with the Assertive Outreach population, my feelings towards CTOs were mainly based upon my ideas about what life might be like under such restrictions. Like many of the staff I interviewed, I felt slightly fearful that a piece of legislation could not only stipulate where one can live and what medication one must take, but also that such constraints could be enforced in one's own home. I could accept, however, that CTOs theoretically offered the potential for care in the community that could facilitate recovery and was curious about how they had been experienced in reality. Participants had been required to review their ideas on the use of compulsion as well as integrate a range of models in the context of this legislation. I was struck by the extent to which clinicians' own professional background had influenced their initial attitude towards this new form of treatment

and how many of those opinions had started to change as clinical experience of the CTO had increased. The application of 'reflective practice' seems particularly important in maintaining awareness of the impact of one's perspective on work and ensuring an open-minded response in the face of its challenge. My views towards CTOs remain mixed, largely because of the diversity in experiences shared by participants. I have an increased awareness of the complex and sensitive nature of the issues involved in their use and whilst I would be less nervous about the idea of working with such powers, I am keen to develop a better understanding of their impact upon clients.

3.3 Issues around Control

The issue of control was an important theme across the data set. Participants shared their fears around working with coercive powers, their experience of the benefits that structure could provide and their thoughts around the impact upon therapeutic relationships. My reflections will be structured around related issues from the perspective of staff, clients and self.

3.3.1 Staff: Responsibility and Anxiety

A level of staff anxiety was apparent in the interview data and seemed to be exacerbated by the complexities surrounding the implementation of the CTO legislation. Participants spoke of various responses to this worry, including sharing responsibility with team members, imposing structured checklists to inform planning and taking time over decisions in an attempt to 'get it right'. Many spoke too of the

way in which the ultimate responsibility rested with the Responsible Clinician, showing a sense of reassurance in deferral to others not dissimilar to that they described as being demonstrated by clients. Participants shared their successes and joys of working with certain clients as well as the sense of frustration and hopelessness generated by others. I became aware of the strength of feeling involved in working with these clients as well as how important it is for staff themselves to feel valued in order that they can effectively work with others. I was conscious also of the way participants responded to being interviewed and how that may convey something of their style with clients. One participant almost 'became the interviewer' by altering questions and revising the order and importance of certain issues. This made me wonder about their style being an attempt to elicit control, perhaps out of anxiety provoked by the situation. My initial response was to adopt a more passive style out of a desire to allow the participant to share their experiences fully; this was replaced with increased structure as the interview progressed and I became aware of the need to cover all questions. Another participant spoke of how, when faced with a client who 'pushes the boundaries', her response was often to enforce them more strictly in order to maintain control. This type of interaction is likely to be influenced by the early experiences of both staff and client (Gray and Mulligan, 2010; Tyrell, Dozier, Teague and Fallot, 1999) and reinforces the importance of reflecting upon one's own personality style and emotional needs when working clinically.

3.3.2 Client: Compliance and Boundaries

Whilst interviewing staff about their experiences of working with people on a CTO, I was intrigued by the variety of client reactions. I heard examples of clients for whom the CTO had enhanced their recovery and their engagement with services and also listened to situations where the CTO had threatened the therapeutic relationship and activated clients' feelings of disempowerment and rage. I became curious about the factors which influence this diversity in response. It seems counter-intuitive on one level to *elect* to be under compulsory powers, and yet that is exactly what some clients had done. For them, deferring the responsibility of their care may have served as an avoidant strategy to protect from a greater level of awareness which may have generated further distress. There were others for whom non-compliance appeared to serve as a strategy for maintaining control. Several participants described the influence of personality issues and one suggested a potential link with attachment theory, ideas which are supported by research into recovery styles (Drayton, Birchwood and Trower, 1998; Tait, Birchwood and Trower, 2004). The client's ability to accept their experience of psychosis and maintain an open and responsible stance to its treatment, impacts upon engagement (Tait, Birchwood and Trower, 2003). An understanding of clients' relationship with their psychosis is therefore important when considering the likely outcomes of the CTO and the usefulness of boundaries as outlined by its criteria.

3.3.3 Self: Managing Perfectionism

I was struck by how my personal style so closely related to the issues raised by the research. Perhaps it is no coincidence; I did after all choose to study this area. Whilst conducting this research I was confronted by my desire to maintain control and 'get things right', aspects which mirrored some of the experiences of my participants. For me, this personality trait was emphasised in the context of increased anxiety triggered by the significance of completing my thesis. Throughout the process as enthusiasm fluctuated, so did motivation levels; sometimes a desire to do well prevented me from moving on to the next stage. From talking with other trainees, I am relieved that this phenomenon is common and from experience I am aware that I am not the only psychologist to demonstrate obsessional traits in some areas. Whilst I do believe that being thorough can benefit one's work, being distracted by assessing your own performance ("am I getting this right?") can distract from the task in hand, and in extreme cases can be detrimental (Covington, 1984). It is another manifestation of an avoidant strategy and can be likened to the responses of staff and clients in the face of distressing stimuli. For me this was crystallised when I found myself spending an excessive amount of time re-analysing a few pages of interview transcript out of concern that something had been overlooked. It was only afterwards that I became aware I had become 'stuck' on a transcript of someone who had shared *their own* tendency to spend too long on tasks out of their personal need to 'get things just right'. Being aware of one's own style is essential in helping to understand the interaction between 'self' and 'other' in the process of both research and clinical work (Mollon, 1989). It is also important to

find ways of managing such anxiety in order to maintain good psychological health (Souza, Egan and Rees, 2011).

3.4 Congruence

The final theme of 'Congruence' was interpretative in nature and arose from a perceived experience of conflict for staff because they appeared to need to integrate the CTO with other models. They were also led to update their ideas around the use of compulsion. This theme also relates to my experiences of research as I applied my own principles to my work and managed the, at times, competing demands of conducting research within the constraints of the doctoral training requirements.

3.4.1 Professional Integrity

Throughout this process I have been aware of ethical responsibilities relating to conducting psychological research. Because of the time pressures faced by staff in the NHS I was keen to minimise the time required of any one participant. Whilst it was not difficult to adhere to basic ethical principles such as 'the right to withdraw' and 'informed consent' (British Psychological Society, 2009a; British Psychological Society, 2009b) I experienced a sense of responsibility towards the data generated, the participants who offered their views and the clients whom they serve. I value the information shared by my participants and have attempted to represent their experiences as best I can. At the same time my thoughts have been with the utility of the research findings and in a study which is perhaps distant from the voice of the

client, I am hopeful that the clinical relevance of the findings will contribute to the continuing work of the AOT and benefit the population they serve.

3.4.2 Clinician and Researcher

Many of the clinical skills I have acquired as a psychologist have complemented my work as a researcher. I found myself more confident towards interviewing than I would have a few years ago and better equipped with psychological theory to interpret my findings at a conceptual level. During clinical psychology training I have improved my ability to work on a range of projects at once; a skill which is also congruent with the process of research. As the project progressed, certain tensions did however arise. Whilst attending a conference on the introductory use of IPA, I had been advised to reduce my sample size because of the small scale nature of my research. In subsequent discussion with my supervisors, it became clear this was not a viable option because of the specific requirements of the thesis. There seemed therefore a tension between 'doing the best IPA I could' and 'doing the best IPA I could whilst also meeting external requirements'. I was challenged to achieve a balance between robustness and achievability and forced to distance myself from the expectations of the depth of analysis I had returned from the conference with. Such need for pragmatism can be likened to the difficulties many clinicians face whilst working in the NHS, where 'ideal outcomes' may not be possible and sometimes doing 'enough' must be enough. Understanding when to stop assessing, end an intervention, or in this case, cease data analysis are critical skills which this process has helped me to continue to develop.

3.5 Conclusion

The empirical research demonstrated participants' need for collaborative working, supervision and self-reflection; conducting the research also reinforced my own need for those elements. The use of supervision has been valuable in helping to focus me throughout this process and as I have explored new areas of working, I have developed an increased confidence in my ability. Understanding my experience of control and anxiety has been a valuable part of this process and supported by maintaining a good balance between life at home and work. Using leisure time to exercise, seek support from friends and enjoy other activities has helped me to maintain a sense of perspective. I consider myself to be a reflective person and am aware of the importance of acknowledging the impact of 'self' upon my work, and maybe work upon the self. My aim is to ensure I continue to practice in a reflective way when faced with new challenges as I begin my career as a qualified clinical psychologist.

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Appendices

Appendix One

Authors Guidelines: Clinical Psychology Review

Preparation

Use of wordprocessing software

It is important that the file be saved in the native format of the wordprocessor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. In particular, do not use the wordprocessor's options to justify text or to hyphenate words. However, do use bold face, italics, subscripts, superscripts etc. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier: http://www.elsevier.com/guidepublication). Note that source files of figures, tables and text graphics will be required whether or not you embed your figures in the text. See also the section on Electronic artwork.
To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your wordprocessor.

Article structure

Manuscripts should be prepared according to the guidelines set forth in the Publication Manual of the American Psychological Association (6th ed., 2009). Manuscripts should ordinarily not exceed 50 pages. Exceptions may be made with prior approval of the Editor in Chief for manuscripts including extensive tabular or graphic material, or appendices.

Appendices

If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Essential title page information

Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible. **Note: The title page should be the first page of the manuscript document indicating the author's names and affiliations and the corresponding author's complete contact information.**
Author names and affiliations. Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author within the cover letter.
Corresponding author. Clearly indicate who is willing to handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address.**
Present/permanent address. If an author has moved since the work described in the article was done, or was visiting at the time, a "Present address"' (or "Permanent address") may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract
A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

Graphical abstract
A Graphical abstract is optional and should summarize the contents of the article in a concise, pictorial form designed to capture the attention of a wide readership online. Authors must provide images that clearly represent the work described in the article. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum of 531 × 1328 pixels (h × w) or proportionally more. The image should be readable at a size of 5 × 13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. See http://www.elsevier.com/graphicalabstracts for examples.
Authors can make use of Elsevier's Illustration and Enhancement service to ensure the best presentation of their images also in accordance with all technical requirements: Illustration Service.

Highlights
Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point). See http://www.elsevier.com/highlights for examples.

Keywords
Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Abbreviations
Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

Acknowledgements
Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

Footnotes
Footnotes should be used sparingly. Number them consecutively throughout the article, using superscript Arabic numbers. Many wordprocessors build footnotes into the text, and this feature

may be used. Should this not be the case, indicate the position of footnotes in the text and present the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.

Table footnotes

Indicate each footnote in a table with a superscript lowercase letter.

Electronic artwork

General points

- Make sure you use uniform lettering and sizing of your original artwork.
- Save text in illustrations as 'graphics' or enclose the font.
- Only use the following fonts in your illustrations: Arial, Courier, Times, Symbol.
- Number the illustrations according to their sequence in the text.
- Use a logical naming convention for your artwork files.
- Provide captions to illustrations separately.
- Produce images near to the desired size of the printed version.
- Submit each figure as a separate file.

A detailed guide on electronic artwork is available on our website:
http://www.elsevier.com/artworkinstructions
You are urged to visit this site; some excerpts from the detailed information are given here.

Formats

Regardless of the application used, when your electronic artwork is finalised, please 'save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):
EPS: Vector drawings. Embed the font or save the text as 'graphics'.
TIFF: Color or grayscale photographs (halftones): always use a minimum of 300 dpi.
TIFF: Bitmapped line drawings: use a minimum of 1000 dpi.
TIFF: Combinations bitmapped line/half-tone (color or grayscale): a minimum of 500 dpi is required.
If your electronic artwork is created in a Microsoft Office application (Word, PowerPoint, Excel) then please supply 'as is'.

Please do not:

- Supply files that are optimised for screen use (e.g., GIF, BMP, PICT, WPG); the resolution is too low;
- Supply files that are too low in resolution;
- Submit graphics that are disproportionately large for the content.

Color artwork

Please make sure that artwork files are in an acceptable format (TIFF, EPS or MS Office files) and with the correct resolution. If, together with your accepted article, you submit usable color figures then Elsevier will ensure, at no additional charge, that these figures will appear in color on the Web (e.g., ScienceDirect and other sites) regardless of whether or not these illustrations are reproduced in color in the printed version. **For color reproduction in print, you will receive information regarding the costs from Elsevier after receipt of your accepted article.** Please indicate your preference for color: in print or on the Web only. For further information on the preparation of electronic artwork, please see http://www.elsevier.com/artworkinstructions.
Please note: Because of technical complications which can arise by converting color figures to 'gray scale' (for the printed version should you not opt for color in print) please submit in addition usable black and white versions of all the color illustrations.

Figure captions

Ensure that each illustration has a caption. Supply captions separately, not attached to the figure. A caption should comprise a brief title (**not** on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables

Number tables consecutively in accordance with their appearance in the text. Place footnotes to tables below the table body and indicate them with superscript lowercase letters. Avoid vertical rules. Be sparing in the use of tables and ensure that the data presented in tables do not duplicate results described elsewhere in the article.

References

Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the Publication Manual of the American Psychological Association, Sixth Edition, ISBN 1-4338-0559-6, copies of which may be ordered from http://books.apa.org/books.cfm?id=4200067 or APA Order Dept., P.O.B. 2710, Hyattsville, MD 20784, USA or APA, 3 Henrietta Street, London, WC3E 8LU, UK. Details concerning this referencing style can also be found at http://humanities.byu.edu/linguistics/Henrichsen/APA/APA01.html

Citation in text

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Web references

As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

References in a special issue

Please ensure that the words 'this issue' are added to any references in the list (and any citations in the text) to other articles in the same Special Issue.

Reference management software

This journal has standard templates available in key reference management packages EndNote (http://www.endnote.com/support/enstyles.asp) and Reference Manager (http://refman.com/support/rmstyles.asp). Using plug-ins to wordprocessing packages, authors only need to select the appropriate journal template when preparing their article and the list of references and citations to these will be formatted according to the journal style which is described below.

Reference style

References should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters "a", "b", "c", etc., placed after the year of publication. **References should be formatted with a hanging indent (i.e., the first line of each reference is flush left while the subsequent lines are indented).**

Examples: Reference to a journal publication: Van der Geer, J., Hanraads, J. A. J., & Lupton R. A. (2000). The art of writing a scientific article. *Journal of Scientific Communications,* 163, 51-59.

Reference to a book: Strunk, W., Jr., &White, E. B. (1979). *The elements of style.* (3rd ed.). New York: Macmillan, (Chapter 4).

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Video data

Elsevier accepts video material and animation sequences to support and enhance your scientific research. Authors who have video or animation files that they wish to submit with their article are strongly encouraged to include these within the body of the article. This can be done in the same way as a figure or table by referring to the video or animation content and noting in the body text where it should be placed. All submitted files should be properly labeled so that they directly relate to the video file's content. In order to ensure that your video or animation material is directly usable, please provide the files in one of our recommended file formats with a preferred maximum size of 50 MB. Video and animation files supplied will be published online in the electronic version of your article in Elsevier Web products, including ScienceDirect: ⊡→http://www.sciencedirect.com. Please supply 'stills' with your files: you can choose any frame from the video or animation or make a separate image. These will be used instead of standard icons and will personalize the link to your video data. For more detailed instructions please visit our video instruction pages at http://www.elsevier.com/artworkinstructions. Note: since video and animation cannot be embedded in the print version of the journal, please provide text for both the electronic and the print version for the portions of the article that refer to this content.

Supplementary data

Elsevier accepts electronic supplementary material to support and enhance your scientific research. Supplementary files offer the author additional possibilities to publish supporting applications, high-resolution images, background datasets, sound clips and more. Supplementary files supplied will be published online alongside the electronic version of your article in Elsevier Web products, including ScienceDirect: ⊡→http://www.sciencedirect.com. In order to ensure that your submitted material is directly usable, please provide the data in one of our recommended file formats. Authors should submit the material in electronic format together with the article and supply a concise and descriptive caption for each file. For more detailed instructions please visit our artwork instruction pages at http://www.elsevier.com/artworkinstructions.

Submission checklist

The following list will be useful during the final checking of an article prior to sending it to the journal for review. Please consult this Guide for Authors for further details of any item.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:

- E-mail address
- Full postal address

• Telephone and fax numbers

All necessary files have been uploaded, and contain:

• Keywords

• All figure captions

• All tables (including title, description, footnotes)

Further considerations

• Manuscript has been 'spell-checked' and 'grammar-checked'

• References are in the correct format for this journal

• All references mentioned in the Reference list are cited in the text, and vice versa

• Permission has been obtained for use of copyrighted material from other sources (including the Web)

• Color figures are clearly marked as being intended for color reproduction on the Web (free of charge) and in print, or to be reproduced in color on the Web (free of charge) and in black-and-white in print

• If only color on the Web is required, black-and-white versions of the figures are also supplied for printing.

Appendix Two

Author Guidelines: British Journal of Clinical Psychology

British Journal of Clinical Psychology: Author Guidelines

Edited By: Julie Henry and Mike Startup Impact Factor: 1.697

ISI Journal Citation Reports © Ranking: 2010: 43/102 (Psychology Clinical)

Online ISSN: 2044-8260

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

• Papers reporting original empirical investigations

• Theoretical papers, provided that these are sufficiently related to the empirical data

• Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications

• Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words (excluding abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via http://www.editorialmanager.com/bjcp/. The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

4. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from here.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

• All papers must include a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, Conclusions. Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

• All Articles must include Practitioner Points – these are 2–4 bullet points to detail the positive clinical implications of the work, with a further 2–4 bullet points outlining cautions or limitations of the study. They should be placed below the abstract, with the heading 'Practitioner Points'.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

6. Supporting Information

BJC is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at http://authorservices.wiley.com/bauthor/suppmat.asp

7. Copyright

Authors will be required to assign copyright to The British Psychological Society. Copyright assignment is a condition of publication and papers will not be passed to the publisher for production unless copyright has been assigned. To assist authors an appropriate copyright assignment form will be supplied by the editorial office and is also available on the journal's website at http://www.blackwellpublishing.com/pdf/CTA_BPS.pdf. Government employees in both the US and the UK need to complete the Author Warranty sections, although copyright in such cases does not need to be assigned.

8. Colour illustrations

Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a Colour Work Agreement form upon acceptance of the paper. A copy of the Colour Work Agreement form can be downloaded **here**.

9. Pre-submission English-language editing

Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

10. OnlineOpen

OnlineOpen is available to authors of primary research articles who wish to make their article available to non-subscribers on publication, or whose funding agency requires grantees to archive the final version of their article. With OnlineOpen, the author, the author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. For the full list of terms and conditions, see
http://wileyonlinelibrary.com/onlineopen#OnlineOpen_Terms

Any authors wishing to send their paper OnlineOpen will be required to complete the payment form available from our website at: https://onlinelibrary.wiley.com/onlineOpenOrder

Prior to acceptance there is no requirement to inform an Editorial Office that you intend to publish your paper OnlineOpen if you do not wish to. All OnlineOpen articles are treated in the same way as any other article. They go through the journal's standard peer-review process and will be accepted or rejected based on their own merit.

11. Author Services

Author Services enables authors to track their article – once it has been accepted – through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated e-mails at key stages of production. The author will receive an e-mail with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete e-mail address is provided when submitting the manuscript. Visit http://authorservices.wiley.com/bauthor/ for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission and more.

12. The Later Stages

The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site: http://www.adobe.com/products/acrobat/readstep2.html.

This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

13. Early View

British Journal of Clinical Psychology is covered by the Early View service on Wiley Online Library. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Articles are therefore available as soon as they are ready, rather than having to wait for the next scheduled print issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. *Human Rights Journal*. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.x

Appendix Three

Author Guidelines: PsyPAG Quarterly

Quarterly Submissions- Guidelines for Contributors

PsyPAG Quarterly welcomes contributions relating to any area of psychology. These might include:

- conference reviews
- departmental reviews
- featured articles
- discussion papers
- research in brief
- work placement experiences
- interviews
- book reviews
- software reviews
- hints and tips

We particularly welcome contributions from areas of psychology not previously or usually featured in the Quarterly.

Contributions should be submitted in English to the editorial team as a word file attachment via the web form here, or email quarterly@psypag.co.uk. Contributions should be written in an accessible style, aimed at a broad based postgraduate psychology audience. Please left align the text. For guidelines on writing style please consult the Oxford Guide to Style, published by Oxford University Press.

References should be kept to a reasonable length and appear in APA format. Please see http://www.apastyle.org for examples.

- Word limits can be 500 – 2500 words depending on the type of contribution.
- Please include details of your university or place of employment.
- The following details are requested to facilitate the review process (please specify if you would like these details to appear in the Quarterly.):-
  - email address
  - telephone number
  - postal address

All contributions are reviewed by the editorial team and accepted or revised at their discretion. Contributors will be contacted for approval before going to press if major alterations are required.

Submission Deadlines:

1 February 2011 for inclusion in the June 2011 issue

1 May 2011 for inclusion in the September 2011 issue

1 August 2011 for inclusion in the December 2011 issue

1 November 2011 for inclusion in the March 2012 issue

Appendix Four

Letter of Ethical Approval

(Research Registry Unit, Coventry University)

TO WHOM IT MAY CONCERN RRU/Ethics/Sponsorlet

30th April 2011

Dear Sir/Madam

Researcher's name:	**Alice Morgan**
Project Title:	**A Qualitative Study Exploring the Experiences of Multi-Disciplinary Member of Assertive Outreach Teams working with Community Treatment Orders**

The above named student has successfully completed the Coventry University Ethical Approval process for her project to proceed.

I should like to confirm that Coventry University is happy to act as the sole sponsor for this student and attach details of our Public Liability Insurance documentation.

With kind regards

Yours faithfully

Professor Ian Marshall

Pro-Vice-Chancellor, Research

Appendix Five

Letter of Ethical Approval

(Research and Development, Coventry and Warwickshire)

Coventry and Warwickshire NHS
Partnership Trust

West Midlands (South) Comprehensive Local Research Network
Fourth Floor, West Wing (ACF40002)
University Hospitals Coventry & Warwickshire NHS Trust
University Hospital
Clifford Bridge Road
Coventry
CV2 2DX

9th August 2011

Alice Morgan
Clinical Psychology Doctorate
Coventry University
Priory Street
Coventry
CV1 5FB

Dear Alice

Project Title: A Qualitative Study Exploring the Experiences of Multi-Disciplinary Members of Assertive Outreach Teams working with Community Treatment Orders
R&D Ref: PAR180411
REC Ref: 11/WM/0142

I am pleased to inform you that the R&D review of the above project is complete, and the project has been formally approved to be undertaken at Coventry and Warwickshire Partnership NHS Trust. Your research activity is now covered by NHS indemnity as set out in HSG (96) 48, and your trial has been entered onto the Trust's database. Please note that Coventry University, as Research Governance Sponsor, is responsible for the indemnity to meet any potential legal liability for the management and design of this research.

The following documents were reviewed:

Document	Version	Date
NHS R&D Application Form	70194/207826/14/739	
NHS Site Specific Information Form	70194/207830/6/777/87890 /211155	
REC Favourable Opinion Letter	11/WM/0142	23/06/2011
Protocol	1	01/04/2011
Participant Information Sheet	2	01/06/2011
Consent Form	2	01/06/2011

Your responsibilities are set out in the attached agreement, which must be signed and returned to the R&D Office. You should keep a copy for your records.

All research must be managed in accordance with the requirements of the Department of Health's Research Governance Framework (RGF) and to ICH-GCP standards. In order to ensure that research is carried out to these standards, the

Trust employs the services of an external monitoring organisation to provide assurance. Your study may be randomly selected for audit at any time, and you must co-operate with the auditors.

The duration of Trust approval extends to the date specified in the R&D application form. Action may be taken to suspend Trust approval if the research is not run in accordance with RGF or ICH-GCP standards, or following recommendations from the auditors. Research must commence within two years of the REC approval date and within six months of NHS Permission.

I wish you well with your project. Please do not hesitate to contact me should you need any guidance or assistance.

Yours sincerely

Debbie Scholes
R&D Facilitator

Enc: PI Agreement

Cc: Sponsor, c/o Professor Ian Marshall
Academic Supervisor, Dr Adrian Neal
Clinical Supervisor, Dr Sally Bradley
SWAOT Team Lead, Charlie Marchi

Appendix Six

Letter of Ethical Approval

(National Research Ethics Service, West Midlands)

NHS
National Research Ethics Service
NRES Committee West Midlands - Coventry & Warwickshire
Prospect House
Fishing Line Road
Enfield
Redditch
B97 6EW
Telephone: 01527 582532
Facsimile: 01527 582540

23 June 2011

Miss Alice Morgan
Trainee Clinical Psychologist
Worcestershire Mental Health Partnership Trust
Clinical Psychology Doctorate
Coventry University
Priory Street, Coventry
CV1 5FB

Dear Miss Morgan

Study title: **A Qualitative Study Exploring the Experiences of Multi-Disciplinary Members of Assertive Outreach Teams working with Community Treatment Orders**

REC reference: **11/WM/0142**

Thank you for your email of 10 June 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering Letter		18 April 2011
Evidence of insurance or indemnity		01 July 2010
Interview Schedules/Topic Guides	1	01 April 2011
Investigator CV		18 April 2011
Letter from Sponsor		18 April 2011
Other: Summary CV for supervisor (Dr Neal)		
Other: Summary CV - Salley Bradley		
Other: Email from Ali Morgan		10 June 2011
Participant Consent Form	2	01 June 2011
Participant Information Sheet	2	01 June 2011
Protocol	1	01 April 2011
REC application	IRAS 3.1	15 April 2011
Response to Request for Further Information		
Response to Request for Further Information		23 June 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

Notifying substantial amendments
Adding new sites and investigators
Progress and safety reports
Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/WM/0142	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Helen Brittain
Chair

Email: Rosa.Downing@westmidlands.nhs.uk

Enclosures: "After ethical review – guidance for researchers" SL-AR2

Copy to: Dr Adrian Neal
Chartered Clinical Psychologist
Clinical Psychology Doctorate
Coventry University
Priory Street
Coventry CV1 5FB

Ms Kelly Spencer
West Midlands South Comprehensive Local Research Network
Fourth Floor Rotunda (ADA40017), West Wing
UHCW NHS Trust University Hospital
Clifford Bridge Road
Coventry CV2 2DX

Appendix Seven

Participant Information Sheet

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF WARWICK

Coventry University

PARTICIPANT INFORMATION SHEET

A Qualitative Study Exploring the Experiences of Multi-Disciplinary Members of Assertive Outreach Teams working with Community Treatment Orders

We would like to interview staff members of an Assertive Outreach Team (AOT) about their experiences of working with clients who are on (or have been on) a Community Treatment Order (CTO) and would like to invite you to take part in this research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Talk to others about the study if you wish and please do ask us if there is anything that is not clear.

Part 1 of this Participant Information Sheet outlines the purpose of the study and what will happen should you agree to take part. Part 2 gives you more details about the conduct of the study.

Part 1

What is the purpose of the study?
The aim of the study is to explore the experience of staff working within Assertive Outreach Teams with clients on Community Treatment Orders. Information will be gained on issues such as how the introduction of Community Treatment Orders has impacted the clinician's role, and the perceived impact on the client. This research will be conducted through the use of interviews.

Why have I been invited?
I am particularly interested in the experiences of *staff* who are working with clients on Community Treatment Orders. As a member of an Assertive Outreach Team, you have been identified as someone who might have experience of working with clients who are, or have been on a CTO. I am interested in speaking to staff members who have been working within the team for the last 2 years, and who have had experience of working with at least one client on a CTO. As CTOs require a whole team approach, I am keen to gain participants from a range of professional disciplines.

Do I have to take part?
It is up to you whether you decide to join the study. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw before being interviewed and up to one month after the interview, without giving a reason.

What will happen if I agree to take part? What will I have to do?
You will be asked to attend an interview at a mutually convenient time; these will take place during summer 2011, at your place of work. Interviews will take approximately 60 minutes, but I would ask that you allow 90 minutes to ensure for any unavoidable delays. During the interview you will be asked open-ended questions about your experiences of working with CTOs; this might include issues such as the practical processes involved or perhaps the impact on your professional role. You will also be asked about your perception of the impact of the CTO on clients.

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Chair of Department of Psychology
Professor Liz Robinson BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

www.coventry.ac.uk

What are the possible risks and disadvantages of taking part?
There a very few possible disadvantages of participating in this study. Involvement requires your availability at work for 90 minutes and will not cause you to incur any financial cost.

What are the possible benefits of taking part?
We hope that you will find discussing your thoughts about the use of Community Treatment Orders interesting. Your views are valuable because they will be analysed along with the content of interviews with other professionals. To date, no other research which considers the perspective of the clinician has been published in the United Kingdom.

What if there is a problem?
Any complaint about the way you have been dealt with during the study will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?
We will not share our list of those involved with other members of the team within which you work. We will follow ethical and legal practice in relation to all the data generated during interviews. Further details are outlined in Part 2.

This completes Part 1. If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Participant Information Sheet: Part 2

What will happen if I don't want to carry on with this study?
If for whatever reason you decide you would not like to participate, that is of course acceptable. You will not be required to provide a reason should you wish to withdraw. If, having participated in an interview, you change your mind about your involvement in the study, please just let the lead researcher know and you will be removed from the research. Your interview tape and all information about you will be destroyed. You will be able to withdraw your consent up to one month from the date of your interview.

What will happen if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by approaching Dr Sally Bradley, who is Clinical Supervisor for the study. Contact details are listed below. This study is covered by an indemnity policy held by Coventry University. Further details are available upon request.

Will my taking part in this study be kept confidential?
Interviews will be recorded in order for the conversation to be transcribed and analysed. This will help to get a good sense of the themes arising from all the interviews that are conducted. The data will then be coded and, as far as possible, analysed anonymously. Please note that it is possible that some of what you say may be quoted in the final report. It is therefore important that you feel comfortable about your views potentially being shared in this way. *No names will be used when the study is written up* but general demographic data will be included. This will outline, for example, how many participants were recruited from a

particular professional discipline. Because of this, some comments *may* be recognised as belonging to a particular person.

The study will be written up as part of a doctoral thesis and submitted during May 2012. Whilst the audio material will be destroyed after the thesis has been examined, the original transcripts of the interviews will be stored securely for 5 years following the research.

The data collected during this study, having been made anonymous, will be looked at by the research supervision team and may be viewed by colleagues on the Clinical Psychology Doctorate course in order to ensure that the analysis is a reasonable representation of the data.

What will happen to the results of the research study?
Once the results have been analysed, they will form part of a doctoral thesis and as such will be submitted according to the University of Warwick guidelines. A summary of the research will be provided to all those who participated, and to the service from which the data was collected. The research may also be submitted to an academic journal for publication.

Who is organising and funding the research?
This study is being undertaken as part of a Clinical Psychology Doctorate at the Universities of Coventry and Warwick. The lead researcher is employed by Worcestershire Mental Health Partnership NHS Trust. Expenses are being covered by Coventry University and the lead researcher's employing trust.

Who has reviewed the study?
The proposal for this study has undergone peer review at the Research Registry Unit, Coventry University. It has also been approved by Coventry and Warwick Research Ethics Committee.

Further information and contact details:
You are welcome to contact the Lead Researcher should you require further information about the study at any stage. If you have any concerns about what happens during an interview, you are also welcome to contact the Clinical Supervisor for the study; details for each are below.

CONTACT DETAILS

Lead Researcher
Ali Morgan, Trainee Clinical Psychologist
Clinical Psychology Doctorate Programme
Coventry and Warwick Clinical Psychology Doctorate Course
Coventry University
Priory Street
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a.morgan@warwick.ac.uk
07952 237513

Clinical Supervisor
Dr. Sally Bradley, Principle Clinical Psychologist
Coventry & Warwickshire Partnership Trust
South Warwickshire AOT
15 George Street
Leamington Spa, CV31 1ET
sally.bradley@covwarkpt.nhs.uk
01926 313126

Appendix Eight

Participant Consent Form

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
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Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF WARWICK

Coventry University

CONSENT FORM

Title of Project: A Qualitative Study Exploring the Experiences of Multi-Disciplinary Members of Assertive Outreach Teams working with Community Treatment Orders

Name of Researcher: Alice Morgan, Trainee Clinical Psychologist

Once you have read the following, please tick the relevant box to indicate agreement to each statement.

1) I confirm that I have read and understood the Participant Information Sheet dated June 2011, version 2 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2) I am aware that participation in this study is voluntary and that I am free to withdraw up to one month after my interview, without giving an explanation. ☐

3) I agree to participate in the above study. ☐

Participant Name: _____

Signature and Date: _____

Name of Person taking consent: _____

Signature and Date: _____

Appendix Nine

Research Process

Research Process

August 2010	Researcher attended a team meeting and spent a day shadowing Clinical Supervisor.
October 2011	Research Proposal submitted to Coventry University
April 2011	Coventry University granted ethical approval
May 2011	Research presented at the Coventry & Warwickshire Research Ethics Committee (REC)
June 2011	REC Approval obtained
August 2011	Research and Development Approval obtained
September 2011	Lead Researcher attended team meeting. Recruitment began.
September – November 2011	Interviews conducted and transcribed
November 2011	Researcher attended a two day conference on IPA.
December 2011 – March 2012	Transcriptions were analysed.
March – April 2012	Research written up.
May 2012	Empirical paper submitted as part of thesis. Research findings disseminated to service from within which the research was conducted.

Appendix Ten

Interview Schedule

Semi-Structured Interview Schedule

Impact on professional role/ Assertive Outreach Team

Can you tell me about your experience of working with someone on a Community Treatment Order?
How would you describe the implications of CTOs being implemented?
How did the introduction of CTOs affect the team?
How has your job been since working using CTOs?
What would you perceive to be the costs and benefits of CTOs?
How do you think other members of your team view CTOs?

Processes involved in using CTOs

How do you find the decision making process when it's agreed that someone will become subject to a CTO?
Can you tell me about how CTOs are reviewed? How do find that process?
What's your experience of people being discharged from an order?

Impact and Effectiveness

How would you describe the impact of being on a CTO for a client? (engagement with services, 'risk' episodes, promotion of independence, relapse/ admission rates, access to social support)
How do your clients feel about being on a CTO?

Appendix Eleven

Interpretative Phenomenological Analysis (IPA)

The process of IPA draws upon the following strategies:

- The close, line-by-line analysis of the experiential claims, concerns, and understandings of each participant (e.g. see Larkin, Watts & Clifton, 2006)
- The identification of the emergent patterns (i.e. themes) within this experiential material, emphasizing both convergence and divergence, commonality and nuance (e.g. see Eatough & Smith, 2008), usually first for single cases, and then subsequently across multiple cases.
- The development of a 'dialogue' between the researchers, their coded data, and their psychological knowledge, about what it might mean for participants to have these concerns, in this context (e.g. see Larkin et al., 2006; Smith, 2006), leading in turn to the development of a more interpretative account.
- The development of a structure, frame or gestalt which illustrates the relationships between themes.
- The organization of all this material in a format which allows for analysed data to be traced right through the process, from initial comments on the transcript, through initial clustering and thematic development, into the final structure of themes.
- The use of supervision, collaboration, or audit to help test and develop coherence and plausibility of the interpretation.
- The development of a full narrative, evidenced by a detailed commentary on data extracts, which takes the reader through this interpretation, usually theme-by-theme, and is often supported by some form of visual guide (a simple structure, diagram or table).
- Reflection on one's own perceptions, conceptions and processes (e.g. see Smith, 2007).

(Extracted from Smith, Flowers and Larkin, 2009, p.79)

Appendix Twelve

Examples of Analysis: Excerpts from two transcripts

behaviours in the past. Thinking about, you know, what might be in terms of kind of a more of a kind of dynamic formulation about that: what might help, what might cause that, you know, what might be going on, what might stabilise that and look at that then I would often chair the kind of meetings around the 'working with risk' documentation and just look at the pros and cons of looking at some of the challenges. So I've probably taken a bigger part of that than I would've done before.

I: Right. And how have you found doing that?

P: Yeah, It's been quite well accepted. And it doesn't feel like I think, the nature of the team is that we're kind of happy to have disagreements and that actually it's not taken personally and it's often useful to have a non medical professional chairing it because you, otherwise, you know, the others: quite a bulk of nurses in the team and then kind of the social worker who's involved in the process anyway, although, but they're quite a small voice and they're quite *junior* within the team. So, you could kind of, you know, they might be somebody to... 'cause although they're involved in the process, their head is at 'what can I do to take, you know, to not enforce treatment?' That's kind of their philosophy, but I think because they're kind of more, newer and junior within the team, I don't think they quite feel like they're able to take that role in kind of a big MDT discussion, whereas I guess I've been in the team a long time, I know most of the people in the team and you know, I don't have a problem asking some of the

Psychologist role as considering impact of past on present.

Formulating predictions around risk

Formulation of risk (CP)

Pulling various aspects together to make predictions.

Psychologist as chair

Emphasis on leadership.

Importance of document as good guiding the thinking process. Role of CP is leading this.

CTO generating a change in role. Creates a need for more reflective practice? or at least a more structured way of working.

CP as leader accepted.

Team accepting of disagreements

'kind of happy' - not happy?

Role of non medical chair

'Personal' left at home - professionalism at work.

CP values non medical chair: uncomfortable at saying its good she chair. Feel need to justify role!

CP = good as not junior, not medical,

Need for confidence in a team when sharing ideas.

Impact of hierarchy: Junior staff lacking confidence

influence of hierarchy on team dynamics.

Should have to share it?

Self importance

Focus of staff on not enforcing treatment.

Avoiding enforcement as a philosophy

Newness to team AND junior status creates harder to share opinion.

Difficulties in involving everyone in MDT discussion

Big MDT - Sounds intimidating.

Can it ever really be MDT if some stay quiet?

Familiarity with teams a feature impacting confidence.

Sam

I: Can you just start by telling me your experience of working with someone on a Community Treatment Order?

P: Ok, I've only worked with people on CTOs during my time in Assertive Outreach, so my experiences is, comes from that perspective. We tend to, my experience of it is there's usually discussion around someone's treatment plan isn't working to the point where it- it *needs* to be considered otherwise if we *don't* there's a risk of just continual breakdowns, continual sort of this sort of self-fulfilling prophecy, sort of well there's no engagement, I keep becoming unwell which I'm declining [laughs] as it were, so *my* experience of it is, initially when we first started them it was quite stressful for me, I found it... I thought 'oh hang on', it didn't well with my ideologies, it was almost as bad as de facto detention when elderly people were kept on wards with doors locked, it was just exactly the same in the community, that was how I perceived it.

I: Can you tell me a bit more about how it didn't fit with your idealogy then?

P: Well, if you're trying to engage people in a creative and flexible way, you *have* to allow them not to engage, otherwise you can't actually do the job. Do you know what I mean? You- You can't get to know that person. If someone is engaged like, you would have it in rehab services, initially they go through a period of *passive* engagement, where they're just doing things because you're kind of supervising

Staff stress

Enforcement undermines engagement

Appendix Thirteen

Superordinate and Emergent Themes

Superordinate and emergent themes for individual participants

KATHERINE

Insight and Shame

Denial of illness	19.
Projection of feelings of 'stuckness' into staff	19.
Anger towards system prevents recovery	18.
Anger towards those who hold power	18.
Suicide risk	18.
Total lack of choice and control	12.
Powerlessness	12.
Self-concept	12.
Area of significant controversy	15.
Insight generates shame	3.
Lack of faith in medication (client)	25.
Adherence (to CTO) creates false sense of wellness	28.
Significant distress despite reduced illness	20.

Attachment Behaviour- Seeking and Resisting Care

Difficulty in accepting care from authority figures	18.
Paternalism of medical model	27.
Influence of personality in accepting care	27.
Influence of personality	21.
Impacts people from all backgrounds- "intelligent and fearful"	8.
Personality type influences restriction	8.
Client independence increases resistance	9.
History of non-compliance	9.
Knowledge of the system creates rebellion	10.
Variability of coping threshold	10.
Independence influences need for care	10.
Coercion as counter-productive	10.
Independence can create resistance which undermines treatment	10.
Role of personal principles	11.
Attitude toward service defined by desire and need	11.
CTO enables and prevents recovery	19.

Self at Work

Respect for client	23.
Staff guilt around control	24.
Place of personal judgement	31.

Team Process

Need for thorough and careful selection	5.
Importance of staff confidence in psychiatrist	5.
Method of managing as important as CTO itself	5.
Differences of opinion within team	15.
Importance of time for discussion	15.
Importance of multidisciplinary discussion	16.
Team cohesiveness	17.
Range of perspectives in team	17.
High confidence in team	17.
Robust nature of tribunal	17.
Weighing up potential outcomes	19.
Responsibility of team	20.

Advocacy

Role of alternative resources	21.
Advocacy	21.
Need for client to be understood	21.
Client offered alternative perspective	21.
Non judgemental nature of peers	22.
Advocacy to confront denial	22.
Marketing of CTO	22.
Hierarchy of mental health clients	33.

Accepting Medication and Enabling Recovery

Medication as main factor in mental health	4.
CTO increasing compliance	4.
Improvement in quality of life	4.
CTO develops acceptance of medication	3.
Facilitation of behaviour	3.
change	
Enforced compliance reduces risk	25.
Increase in insight enables relapse prevention work	26.
Recovery as self-perpetuating cycle	20.
Broad definition of what enables recovery	30.
Treatment before recovery	26.
Cyclic experience of relapse and recovery	26.
Stability creates receptiveness	26.
Medication only part of recovery	23.
Recovery as process	23.
Recovery focus of AOT	24.
Being settled creates a momentum	30.
Total change in client	26.
Changed triggered by CTO	26.
Recovery becomes self-fulfilling prophecy	14.
CTO enhances self-concept	13.
Stability of mental health increases self-awareness	14.
Relationships made easier by reduction in paranoia	14.
CTO allows positive relationships	14.
Capacity for enhanced quality of life	14.
'unwell' view vs. 'well' view	14.
Medication reduces illness	13.
Consistency of medication allows recovery	13.
Medication alters world view of client	13.
Compliance reduces distress	13.
Wellness creates opportunity for recovery work	12.

Reclaiming a sense of Agency

CTO can only benefit clients if they allow it	19.
Difficult to regain control after team has held it	20.
Need for acceptance of client	21.

Ethical Concerns

AO staff as 'moral agents'	19.
'Safety net' vs. 'violation of rights'	28.
Staff concern around quality of life and rights	5.
Liberty	6.

Enforced legal authority contradicting freedom	6.
Conflict between independence and restriction	6.
Fear of removal of liberty	6.
Unjust control	6.
Restriction as punishment	6.
Uneasiness of restriction	6.
CTO as abuse	7.
Abuse of power	7.
CTO as significant power	8.
Potential for punitive use	5.
CTO as potentially dangerous	11.
Fears around negative impact of CTO	11.
Negative impact on quality of life and self-concept	11.

Impact of Illness on Client

Social isolation resulting from non compliance	3.
Impact of mental illness on faith	3.
Impact on family	25.
Mental illness as restrictive	25.
Client role as parent	25.
Illness reduces engagement	13.
Quality of life impacted by illness	13.
Conflict in self-'ideal' vs. 'ill'	13.
Barriers to accessing help	19.

Frustration around Inadequacy of Support

'Shortsightedness' of systems	31.
Client deserves compensation	30.
System as unjust	30.
Compliant client deserves more	30.
Frustration at what is offered to the client	31.
Political implications of care provided	31.
Identification of intervention need	24.
CTO should offer tangible benefits	22.
Need for self-development	22.
Shortsighted focus on medication	22.
Responsibility to offer more than medication	23.
Opportunity to intervene not taken	23.
Lack of interagency working	31.

Control Experienced as Safety

Dependency enables independency	30.
Client elects CTO	1.
Safety	1.
Control generates safety	2.
Fear of freedom	2.
Confinement reframed as security	2.
Restriction offers safety	2.
Dependence	2.
Safety as first priority	2.
Client 'insight' into reduced insight	15.
Conscious deferral of control	15.
Complexity of client choice	16.
Passivity of clients	9.

Cohort Effects

Changing levels of insight	28.
Generational differences in attitude to CTO	29.
Older adult satisfied with 'maintenance' treatment	29.
Young person seeks recovery	29.
Differences in expectation of quality of life	29.
Institutionalised client experiences CTO as comforting	27.
Vulnerability of institutionalised	2.
Dependency created by 'old school' psychiatry	27.

Changing Attitudes

Client adjustment to accept CTO	11.
Now accepted benefits outweigh cost	16.
Perception of CTO creating adversity	4.
False expectation of client resistance	24.
Expectation of objection	15.
Experiences of CTO alters perspective	1.
Positive staff experience	1.
Negative staff expectation	1.
Staff surprise at clients positive response to CTO	1.
False expectation of client being against CTO	2.
Caution of team early on	5.
Initial strong concern regarding ethics	7.
CTO attitude shift	7.
Abstract fears replaced by positive experience	7.
Service user fear	8.
Benefits greater than client expected	20.
Increased comfort with CTO	16.
Contentment with process	16.

Need for Education

Need for understanding to alleviate fear	33.
Difference between knowledge of 'what law' and 'how practised'	34.
Common lack of understanding of CTO	34.
Ignorance of general public	31.
Lack of clear information	32.
Fear of CTO	32.
Need for increase in public awareness	32.
Importance of understanding the context of CTO	32.
Scaremongering around CTO powers	32.
Demystification of modern powers	32.
Suspicion of 'regime'(staff and client)	33.
Inaccessibility of information	33.

JAMES

Unexpected Successes

Client enjoyed recall	24.
Surprised by effectiveness	25.
Effective engagement	25.
Simplicity of process	24.
Less anxiety for staff	24.
Less stress for clients	24.
Surprised by clients' response	22.
Requesting a CTO as counter-intuitive	22.
Evaluation of client and staff experience	23.
Exceeded expectation	23.
Learning triggered opinion change (staff)	22.
Aims met	28.
Reduction in challenges of mental health act	12.

Coercion of *staff*

Requirement to justify *not* using it	10.
Enforcement of staff	9.
Defensive practice	9.
Compulsion conflicts with team identity	5.

The Worst kind of Restriction

Medication and side effects	17.
Depressing for clients to have appeal rejected	31.
The extent of the powers	15.
Invasion of privacy	15.
Change of client opinion: keen - hatred	16.
Longer term nature of CTO	17.
Less freedom for client	17.
'revolving door' admissions as finite	17.

Awareness of Staff

Team awareness of process	21.
Value of educating staff	21.
Opinions inform decisions	21.
Training prevents misinformed opinions	21.
Awareness of warning signs	13.

Ethical Concerns

Unhelpful if used as 'shortcut' to engagement	29.
Avoiding temptation to force engagement	29.
Not THE answer	30.
Fear of potential overuse	35.
Staff/ CTO as something to blame	
Concern of 'lobster pot'	33.
Justifying frequency of use	29.

Subjective Nature of Implementation

Style of implementation	30.
Gentle approach to CTO criteria	25.
Capacity for clinical judgement	26.
Flexibility of conditions	26.
Contextualising interpretation of criteria	26.

Positive Aspects of CTO

Capacity to work flexibly	10.
Not seen as 'quick fix'	29.
Scope to manage more closely and more timely	29.
Cumulative effect of 'repeated recovery'	30.
Quicker response to relapse	30.
Improved insight and collaborative working	30.
Affords protection of self and others	28.
Positive impact of engagement	26.
Effective symptom management	28.
Increased potential for mental stability	28.
Provision of long term stability	25.
Enabled better engagement	25.
In the background	26.

Vulnerability of Staff

Working with intimidating clients	23.
Staff safety	23.

The Intervention

Typical clinical intervention maintained	26.
Medical model	28.
'sensible' approach to forcing therapeutic groups	33.
Motivation required to change	34.
Generate confidence- of client and staff	35.

'Beyond Psychosis'

Substance misuse	28.
Impact of substance misuse	28.
Avoided conditions re. substance misuse and place of residence	33.
Meets aims- fails to help personality issues	28.
Challenge of personality disorder	18.
Rules provoke clients with Personality Disorder	27.

Collaborative Decision Making

Team discussion	6.
Pragmatism vs. Technical focus	22.
Balance of perspectives in the team	22.
Balance of costs and benefits	15.

Removal of CTO

Limited experience of discharge	32.
Discharge triggered by deterioration in physical health	32.
Transpired client was not compliant (while on CTO) anyway	32.
Inaccuracy of judging compliance	33.
Client experience same 'on' and 'off' CTO	33.
Challenge of removing CTOs	34.

Working with the System

Systemic context- working with wards	1.
Communication difficulties	2.
Involvement with RC	2.
Communication around care plan	31.
Multi-agency protocol	3.
Response from other services	8.
Frustration of waiting for police	23.

Therapeutic Relationship – Influences and Implications

Paternalism vs. Openness	7.
Openness of team	7.
Negotiation around medication	7.
Promotion of honest discourse	6.
Effective in context of intensive support	35.
Honesty of staff to clients	32.
Aim to increase collaboration and trust	35.
Equip and empower coping	35.
Team familiarity with clients and risk	12.
As successful as the care plan	12.
Importance of relationship	30.
Therapeutic	15.

relationship	
Dynamic altered by mere existence of CTO	16.
Rapport and trust	26.

Individuality of Client

Individual approach to ending	34.
Management of ending important for 'contentious' CTOs	35.
Individuality of response	15.
Individual	13.
Individual	12.
Individual response to boundaries	14.

Adjustment

Early process issues	2.
CTO as mysterious	1.
Developing trust in the process	1.
Comparison with previous legislation	10-11.
Comparison with previous legislation	11.
Comparison with other legislation	14.
Complex and mysterious	22.
Similarity of assessment process	19.

Structure and Containment

Change in perspective as trainee to qualified	24.
Greater responsibility triggers uncertainty	24.
Pressure of responsibility	24.
Organised structure and increases clarity	24.
Paraphernalia of authority	13.
Structure replicates containment of hospital	13.
CTO as structure- care plan as intervention	30.
Clients unexpected acceptance	5.
Predictability of boundaries	6.
Sharpens clarity of process	8.
Benefit of structure for staff and client	8.
Rigid structure helps	11.
Respect for authority	14.
'Institutionalised' acceptance of powers	16.
Complexity of clients who prefer hospital	27.
Structure allows flexibility	27.
Attempts to create explicit criteria for removal	33.
Explicit and clear	24.
Regularity of tribunals	31.
increases formality	

Sense of Significant Responsibility

Communicating level of risk and complexity	23.
Increased responsibility of RC	23.
Relief of deferring responsibility	23.
Pressure to get it 'right'	18.
Perfectionism	18.
Sense of responsibility over discussion	18.
Importance of long and broad assessment	18.
Change in focus of decisions for AMHP	19.
Pressure of discharge decision	19.
Responsibility around prediction of risk	19.
Desire to assess thoroughly	18.
Importance of 'slow' decision	19.
Impact of personal style on work	20.
Perfectionism and indecision	20.
Level of responsibility for decision making	20.
Managing uncertainty in decision making	20.
Responsibility of decision making	4.
Legislative complications	4.
Thorough knowledge of legislation	4.
Staff anxiety	5.
Responsibility of ending CTO- 'risking significant risk'	34.
Fear of missing things	3.
Responsibility of services	3.
Anxiety around getting it right	3.
Questioning self- desire to say the 'right' thing	27.
Anxiety of use in other teams	35.
Reality of risk triggers difficult decisions	32.
Checking decisions with colleagues	19.
Fear of getting it wrong	19.
Concern over technical details of CTO	21.

DIANE

Decision Making- Influences and Issues

Alternative perspective- client, carer	17.
Flexibility of team	19.
Team accepting of disagreements	20.
Reflective practice groups	21.
Recall due to poor compliance	22.
Aggression, risk behaviour and substance misuse as indicators for mental health decline	22.
Clarity of staff roles	8.
Role of team discussion	17.
Difficulties in involving everyone in MDT discussion	20-21
Role of informal discussions	21.
Role of supervision in considering issues	21.
Discussions aided by familiarity with the team	21-22
Difficulty in determining threshold for recall	23.
Controversy heightened as risk is lower	24.
Inevitable cycle of disengagement	14.
Culpability of whole team	15.
Controversy amongst team as a safety mechanism	15-16
Decision making- role of devil's advocate	16.
Environmental context of decision making	16.
Familiarity with client as protective feature	16.
Personal approach of psychiatrist	7.
Uncertainty around planning	7.
Importance of multi-agency discharge	7.

Pressure to 'get it right'

Anxiety around removal of CTO	4.
Imposed pressure on staff	6.
Staff anxiety and pressure to overcome it	14.
Personal accountability	15.
Pressure on staff to get it right	15.

'Powerless' and 'Powerfulness' of self

Impact of hierarchy: lack of confidence in 'junior' staff	20.
Psychologist as representative of junior staff	21.
Self importance	21.
Lack of clear policy to protect staff	23.
Staff protection	5.
Vulnerability of staff	22.
Defensive practice	5.
Control removed from staff	17.
Policies as protective	16.
Staff loss of control	12.
Self importance	19-20
Selection of information for report	11.
Team confidence	16.
Psychologist as chair	20.
Conflict between staff and client	23.

'Powerless and powerfulness' of clients

Clients at the 'bottom of society's pool'	34.
Clients as uneducated	28.
Control of client	23.
History of abuse	23.
Fighting forced decisions	23.
Coercion of client	12.
Aversive nature of legal process- 'team versus client'	11.
Client lack of engagement	8.
Passivity of client	8.
Client Anger	10.
Importance of right to appeal	10.
Report illicit client shame	11.
Denial of client	11.

'Powerlessness and powerfulness' of CTO

Powerlessness of CTO	23-24
Power dynamic	5.
Authoritative language	9.
Significance of reports	31.
CTO as lower threshold for recall criteria	34.
Clinical work unaffected by CTO	19.
Poorly written specifications	25.

Addressing the power balance

Lack of inclusivity	34.
Tribunal undermines collaboration	31.
Balance of gain must be redressed	30.
Inaccessibility of legal process to client	28.
CTO not client centred	28.
Insufficient focus on client perspective	28.
Need for client choice	28.
Improvements in collaboration required	29.
Needs based engagement	80.
Preference of elective engagement	27.
Compromise and negotiation	23.
Capacity for negotiation increased without CTO	13.
AO proactive engagement style	12.
Holistic approach threatened	12.
Intensive input	12.

Impact on staff

Compulsory extra workload for staff	32.
Enforced work	32.
Coercion of staff	33.
Pressures around time and work	33.
Reduced client work as a result of administrative tasks	33.
Reduced job satisfaction	33.
Staff anxiety regarding therapeutic relationship	33.
Tribunals as uncomfortable for staff	33.
Creation of paperwork	31.
Stress of workload	31.
Impact on therapeutic relationship	11.

Risk

Risk	5.
Public protection	5.
Threat to public justifies CTO	15.
Balancing outcomes of risk management	15.
'Grey areas' of predicting risk	15.
Crime risk	14.
Low engagement increases risk of serious outcome	14.
Legitimacy of CTO as preventing risk	14.
Threat of risk	13.
Good relationship as resilience factor against risk	13.
Risk averse tribunals	19.
Role of psychology in formulating risk	19-20
Formulating predictions around risk	20.
AOT confidence in managing risk	17.
Minimising risk	17.
Protection of early intervention	13.
Over-simplicity of tribunals	19.

Influence of Expectations

High hopes for CTO	33-34
Expectation early intervention	33.
Realisation of limited benefits of early intervention	35.
Professional view influences clinical practice	32-33
Ambivalence around concept of compulsory psychosocial intervention	26.
Staff expectation of CTO as negative	4.
Compulsion should be unwanted	4.
Appeal of CTO as unexpected	5.
Attentional bias to negative	35.
CTO could provide supportive framework for CMHT	26.

Measuring Outcomes

Difficulties in measuring outcomes	35.
Hard to generalise experience	35.

of AO	
Importance of independent review	31.
Limited experience makes evaluation difficult	26.
CTO as 'work in progress'	18.
CTO as evolving process	6.
Pre-evaluation stage	25.
Difficulties in quantifying success	9.
Indicators of success: increased compliance and reduced admissions	9.
Difficulty in moving people on	17-18
Process of review and feedback	16.
AO as slow work	18.
Evolving process	17.
Currently low CTO rate	17.
Subjective nature of removal process	18.

Services as 'Parent'

Attachment theory and its link to recovery and insight	30.
Service can re-enact abuse	24.
Appeal of Structure and Security	1.
Containment	2.
Responsibility- of clients and professionals	2.
Self-acceptance via deferring control	2.
Attachment style	2-3
Safety of imposed boundaries	3.
Importance of structure	3.
Client experience of relationship	3.
Practical implications of CTOs- enables increased support	25.
Clients desire to be visited	25.
Experience of relationships with services	30.
Role of AO in developing clients' independence	18.
Therapeutic relationship	30.

Evidencing Mixed Responses

Conceded benefits of enforcing medication	34.
Individual experience	1.
Positive experience for clients	2.
Benefits seen by unwilling clients	25.
Unhelpfulness of CTO in non-psychosis areas	24.
Client group categories: high risk, 'like it' and mixed	24.
CTO used with those whose non-compliance affects their recovery	24.
Team are clear CTO is beneficial to some people	22.
Uselessness of CTO for some	22.
Poor efficacy	8.
CTO as maintainer of compliance	8.
Potential for 'it to go either way'	13.
25% of clients like it	30.
Clients settled on CTO	18.

Counter-intuitive Nature of CTO

CTO creates barriers	18.
Prevention of engagement	9.
Conflict between AO engagement and CTO	10.
Disingenuous nature of consenting to be coerced	27.
'Weirdness' of CTO	27.
'Necessity of agreement' alongside 'agreement making CTO unnecessary'	27-28
CTO overlooks intervention	34.
CTO overlooks relationship issues	34.
Hypocrisy of CTO	31.
CTO is devious	29.
Hypocrisy of CTO	29.
Lack of meaning to need for informed consent	29.
Conflict between coercion and engagement	27.
Collaborative nature of work threatened	9-10
CTO creates a barrier to engagement	10.
Engagement problems undermine success	9.
Compulsion impacting on other areas of client need	10.
Informed consent	27.

Anti-Psychiatry Perspective

Discomfort with diagnostic model	32-33
Report encourages focus on illness	32.
Medical model overlooks social factors	32.
Not just about medication	30.
Psychiatry as separate from reflective space	21.
Conflict with psychiatry	21.
Frustration towards narrow focus of CTO	12.
Client perception of staff as 'medication pushers'	12.
Focus on medication	8.
'Anti' psychology to be compulsory	26-27

'Medical Model' of CTO

Standard nature of CTO conditions	26.
Accessibility of team and medication compliance as key terms	26.
Psychosocial interventions not part of CTO	26.
Care as judged by doctor	29.
Medication as purpose of CTO	26.
AO and diagnostic led referral criteria	25.
Bipolar as small group	25.
Psychosis as main criteria	25.
Role of non-medical chair	20.
Responsibility of psychiatrist	14-15.
Negative focus on CTO	8.
Social factors overlooked	10.
Minority of personality issues	25.

Frustration with other Services

Frailty of inter-service relationships	23.
Trust unsupportive of team	23.
Team unsupported by police	22.
Inpatient unit as less clear	16.
Differences of opinion between community and ward staff	17.
Distrust in inpatient involvement	16.
Poor communication and inter-team dynamics	6.
Impact of environment/ systemic changes	6.
Impact of staff turnover	6.
High staff turnover	6-7.
Team decision undermined by inpatient staff	23.
Ownership of care across the levels	7.

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Professional Identity & Team Working

Confusion over roles	2.
Interagency tension	2.
Negotiating the allocation of responsibilities	3.
Conflict between role as care co-ordinator and own profession	10.
Team discussion	20.
'Preciousness' of professional identity	30.
Desire for clearer information sharing (within and between services)	26.
Supervision and team discussion	12.
AMHPs as ultimate decision makers	21.
Better MDT integration required	26.

Lack of Information and Training

Early unfamiliarity with process	1.
Training and staff confidence	31.
Uncertainty around practicalities	18.
Need for regular training	18.
Lack of awareness of terms	21.
Poor communication within team	21.
Perception clients clearer than staff	26.
Need for better information sharing within team	20.

Risk

Prevents escalation of risk	3.
Responsibility of risk	7.
Staff safety	9.
Necessity of restriction	23.
CTO not intensive enough for some	28.
Increase in family safety	27.

Emotional Strain on staff

Emotional strain on staff	6.
Staff guilt	6.
Frustration at clients insight	8.
Impact of emotional involvement on work	16.
Staff anxiety	18.
Self doubt regarding intervention	19.
Staff burnout	31.
Guilt at withdrawing from the disengaged client	31.

Holistic Approach

Medication as stepping stone to therapeutic work	30.
Responsibility to offer holistic approach	30.
Dividing the function of visits	30.
Use of care plans- too professionally led	29.

Frequency of Use

Fear of overuse	16.
CTO as 'easy option'	16.
Appropriate use of CTO	23.
Helpfulness of review system	23.
External review prevents complacency	25.

The 'Angry Patient'

Client anger towards medication	6.
Non compliance as only element of control	6.
'Stuckness' makes progress unattainable	8.
Challenge as focus of discussion	6.
Focus upon depot prevents therapeutic work	9.
Anguish and upset	7.
Patient response to staff	27.
Mixed response to boundaries	16.
Collaborative approach not always effective	16.
Polarisation of client/ worker roles	11.

Culture of the Team

Overall positive perception in team	18.
Thoughtfully implemented	16.
Importance of consultant approach	16.
Importance of feeling involved and listened to (staff)	24.

The Treatment

'Silly' to force therapeutic groups	21.
Inappropriateness of enforced social intervention	22.
Client reluctance to engage in sports group	22.
Medication as main focus of CTO	22.
Treatment generated improvements	8.
Cultural attitudes towards medication	11.
Associated lifestyle	12.
improvements	

Deferring Responsibility

Acceptability of CTO to some	14.
Comfort of deferring responsibility	14.
Lack of choice creates security	14.
Hospital as escape	10.
Avoidance of client	13.
Elective enforcement	15.
60% happy	15.8
Locus of control	16.
Influence of personality	11.

A Focus on Relationship

Impact of CTO on therapeutic relationships	5.
Deterioration of relationship	6.
Participation improves relationship	15.
Clients experience of being 'ganged up' against	27.
Impact on clients' personal relationships	27.

Managing Uncertainty

Positive outcome despite 'messy practicalities'	3.
Lack of clarity from team	7.
Implementation of clearer boundaries	13.
Individual variations	14.
Picture clouded by substance misuse	12.
Uncertainty about managing conditions of CTO	20.

Process and Practicalities

Creates easier access to support (client and partner)	4.
Reduced trauma of admission	4.
Reduced risk improves treatment options	5.
Assessment criteria: independent compliance	24.
Long term potential yet to be established	25.
Key factors: boundaries, lack of insight, needing treatment	28.
Boundary of CTO (/clear care plan) effective for 'chaotic' client	28.
Pressure on resources	31.
Pressure of increased tribunals	19.
Workload is manageable	19.

HEATHER

Utility of Other Models

Role of psychology	10.
Psychology input insufficient in monitoring risk	10.
Sense that psychology is unhelpful	10.
Enforcing groups	14.
Ineffectiveness of groups	15.
Unequipped to work beyond medical model	26.
Social model of mental health as unattainable	27.
Importance of OT and Psychology to support concordance	24.

Identifying Needs

Availability of resources	10.
Confidence and empowerment	27.
Need for greater use of concordance therapy	36.
Resource limitations	25.
Internalising control	27.

Evolving Attitudes

Idea CTO worse than reality	21.
Clients' resistance lessens	18.
Initial protest subsides	29.
Opinion of CTO improved	5.

Positive 'Side Effects'

Simplification of admission process	3.
Enables continuity of care	3.
Family Involvement	2.
Admission as more pleasant experience	4.
Distress limited by swift intervention	7.
Shorter period of detention	8.
Enables faster recovery/ shorter admission time	8.
Avoids 'trauma and logistics' of fresh assessment	1.
Provides Boundaries	1.
Deterrence against non compliance	1.
Positive effect on clients	5.
Prompts medication adherence	5.
Quicker recall	6.
Emphasis on Monitoring	6.
Improves monitoring of risk	21.
Prevents significant deterioration	21.
Safety of boundaries	29.
Protection of public and self	10.
Partnership working	15.
Easier to consider admission	33.

Ethical Concerns

Fear of 'police state'	4.
Restriction	2.
Fear of Intrusion	3.
Service users treated as criminals by police	4.
Informed Consent	2.
Easier to continue than remove	23.
Uneasiness around process	23.
Ethically unjustifiable criteria	15.
Hidden but weighty legislation	18.
Duty to clarify criteria	20.
Alternative to engagement	9.
Sense of uneasiness and uncertainty	22.
Freedom vs. Intervention	14.
Authenticity of consent	28.
Potential costs and benefits of earlier recall	34.
Minimal length	22.

Justification of Use

Used appropriately	6.
Reduction in frequency since introduction	11.
Enforcement only triggered by illness	11.
Change in frequency of use	9.
Staff ability to refuse and shape CTO	13.
Boundaries prevent 'manipulation'	30.
Too soon to evaluate ending	23.
Previously unclear legislation created delays	35.
Restriction as protection	22.

'Acting Out'

Used out of frustration	8-9.
Staff response to 'difficult' clients	17.
Risk of 'punitive' use of CTO	36.
Safeguarding 'personal' use of CTO	17.
Value of external review	17.

Factors Influencing Effectiveness

Relationship with RMO as influencing factor	32.
Impact of previous experience of admission	32.
Personality Disorder	1.
Effective for those who: frequently relapse, lack insight	9.

'Self' at Work

Staff Burnout	9.
Staff burnout	11.
Nervous about sharing opinion	1.
Fear of saying the 'wrong' thing	8.
Conflict with sense of self	21.
Frequent Reassurance seeking	23.
Avoidance of underlying emotional issues	26.
Anxiety around clients' distress	26.

Job Role

Job role unchanged	16.
No difference 'day to day'	23.
Additional workload	17.

Team Dynamics

Variety of perspectives within team	11.
Authority of RMO and AMHP	12.
Difference in perspective amongst team	12.
Key role of AMHP and RMO	12.
Team Hierarchy	30.
Team dynamics of sub-groups	30.
Greater experience = greater weight of opinion	31.
Ethos of negotiation	19.

JANE

Evaluating Tribunals

Need for better client representation	27.
Solicitors unprepared	27.
'Quality assurance' role of tribunal	28.
High frequency of challenging the CTO (early on)	29.
Limited understanding of solicitor	30.
Tribunal protects integrity of process	25.
Difficulties justifying continuation of the CTO	16.

Boundaries and Power

Resistance of boundaries for 'personality disorder' clients	21.
Managing need *for* and resistance *to* boundary	21.
Authority of paternalism	23.
Passivity of the institutionalised	23.
Impact of personality on compliance	20.
Staff hold ultimate control	22.
Power struggles and conflict of opinion	30.
Vulnerability of clients in the community	11.
Vulnerability of client (at tribunal)	30.
Powers create significant responsibility	31.
Cohort effects	23.
Working with a power dynamic	6.
Removal of control	2.
Strict enforcement	3.
Risk of meeting staff needs not clients	9.

Staff wellbeing

Fear of overuse	15.
Staff increasingly comfortable with them	15.
Emotional impact on staff	43.
Impact of coercion on nurses	6.
Process as supportive (for staff)	7.
Staff supported by CTO criteria	9.
Avoiding emotion	44.
Demand characteristics (saying what should be said?)	41.

Collaborative Working

Importance of collaboration within team and alongside clients	33.
Collaborative decision making	8.
Agreement of clients affirms staff	29.
Emphasis on team discussion	14.
AOT's collaborative approach facilitates CTO team discussion	5.
Responsibility shared amongst team	5.
Service user involvement	17.
Preparatory work of CTO	22.

Time Management

Re-distribution of workload	24.
Difference in way work time is spent	25.
Increased workload	15.
Individual nature of time required	33.

Variation in client motivation to change

CTO ineffective when client desires admission	36.
Client need for containment	36.
'Love' of hospital-admission as an escape	36.
Ambivalent attachment style	37.
Meaninglessness of enforced psychology	37.
Psychology as important as medication	38.
Readiness required for psychological input	38.

Individuality of Implementation

Not effective for all	11.
Negotiation within set boundaries	39.
Adaptability of structure	40.
Personal judgement around implementation of boundaries	40.
Negotiability of CTO	22.
Generic process for all AOT clients	34.
Mixed responses from clients	1.

Benefits and Successes

Successful removal of CTO	29.
Client more willing to accept brief admission	12.
Enables better discharge planning	13..
Powers stop 'revolving door' care	14.
Positive experience of discharge	33.
CTO as a tool to aid process	34.
Effective use of recall	12.
Reduction in relapse	10.
Several (5-10) clients discharged	34.

Valuing a Holistic Approach

Holistic approach used	11.
Co-ordination of social support	12.
Variety of treatment offered	10.
Requirement for holistic treatment	42.
CTO as one aspect of wider care	19.
Allows 'beyond medication' focus	20.
Psychoeducation for family	18.
Same care plan; greater force	19.

Diagnosis led service

Medication seen as priority	42.
Medication creates stability	18.
Authority of medical perspective	9.
Detecting non-compliance	16.
Comorbidity: psychosis and personality disorder	20.
Developmental phases of psychosis	35.
Increase in personality disorder in the service	21.
Client against depot	11.

Concept of Recovery

Recovery as a natural maturation process	17.
Recovery as a process	18.
Reduces recovery time	13.
Maturation process and recovery	35.

Reflective Practice

CTO transcended expectations	41.
Observing effectiveness of CTO altered perspective	43.
Maintaining mindful approach	43.
Use of peer supervision	43.
Tribunal triggers reflection on process	25.
Analysis of costs and benefits	7.
Reflective practice facilitated by supervision	7.

Risk

Relapse as biggest risk	31.
Positive effect on risk management	31.

Indirect reduction of risk associated with CTO	32.
Open dialogue around risk	32.

Impact on engagement

Changing pattern of engagement	36.
CTO enables access	37.
Engagement enables other interventions	18.
Diminished insight creates engagement difficulties	2.
Self-perpetuating cycle of wellness and engagement	32.
Adjusting to new role	43.
Impact of cultural values on engagement	24.

Evaluating CTO Criteria

Potential for other criteria, eg. housing	42.
Criteria require further thought	40.
Difficulties in enforcing terms beyond medication	41.
Criteria mainly focus on address and medication	38.
Need for realistic (enforceable) criteria	39.
Alcohol habit	39.
Need for broad treatment and minimal criteria	42.
Questioning value of enforced psychology	41.
Criteria focus on address and medication	10.

Context of Relationship

Use of long term therapeutic relationship	2.
Relationship dynamics at tribunal	26.
Balancing the needs of the relationship and the care	26.
Mutual trust in the therapeutic relationship	17.
Good relationship enables better assessment	4.
Access requirement benefits relationship	10.

DAVID

Elective Compulsion: Deferring control

Choosing no choice	7.
Added complexity of personality disorder	8.
CTO prevents personal accountability	9.
Compulsion potentially harmful for clients with personality disorder	9.

Reflections on Success

Measuring success	24.
Bed days, quality of employment and satisfaction	24.
'Time well' as mechanism of change	22.
Self-fulfilling cycle of treatment	24.

Risk and Relapse

Used in unpredictable relapse cases	1.
Identifying signs of relapse	1.
Families in support of CTO	34.
Pattern of relapse as important as level of risk	23.
Risk an issue for all CTO clients	23.
Reduction of risk	24.
CTO can prevent relapse and admission	20.
Significant benefit for some clients	7.

Team Experience

Team usually autonomous	34.
Team confidence	31.
Increased workload for social workers	29.
AOT more experienced than inpatient staff	31.
Emphasis on justifying freedom not restriction	33.
Feeling stuck	2.
CTO clients inherited from other services	13.
Suggested by medic to team	14.
CTO not yet fully embedded in review	16.
Environment of tribunal aims to facilitate openness	17.
Increased workload	6.

Sharing Personal Experience

Comparison with previous (less helpful) legislation	2.
Majority of work unchanged	29.
Managing 'unhappy people'	18.
Ambivalence around use of CTO (with some)	8.
'Compulsion' as a necessary part of AO work	3.
Increased authority triggered by increased risk	4.
Using a regular threat	18.
Role of RC in assessing engagement	19.

Beyond Medication

Other input as effective as medication	26.
Uncertainty about the place of other interventions	26.
Difficulties with enforced therapy	26.
Medical treatment enables effectiveness of other interventions	24.
Pointless widening CTO criteria beyond medication	25.
Medication as only one part	9.
Universality in experience of treatment for CTO and non CTO clients	27.

Managing Endings

Individuality of length of CTO	22.
No CTOs ended to date	17.
Suggested 2-3 yr lifespan of CTO	17.
Indicators for ending: insight, engagement and compliance	18.
Limited time spent considering ending CTO	18.
Phased plan to remove CTO	15.
Good practice to plan removal	15.
Could take a long time to be ready to end	15.
Difficult to predict length of CTO	15.
Varying threshold for removal of CTO	23.

Maintaining Focus on Recovery

Contradicts recovery ethos of AOT	3.
CTO risks laziness in clinicians	27.
Proactive engagement vs. Lazy compulsion	4.
Recovery period enables increased insight	21.

Confusion

Insufficient training for inpatient staff	30.
Confusion of ward staff	30.
Confusion around process of inpatient staff	30.
Probably lack of client understanding	35.
Confusion over terminology	31.
Recall whilst RC absent	32.
Confusion over terminology	6.
Confusion over mental capacity	6.

Legislative Flaws

Limited evidence base	3.
Issue with timeframe to see 2nd opinion doctors	31.
Need to address 'grey areas' of legislation	32.
Legislative flaws	32.
Lack of clarity around certain aspects of legislation	33.
Inappropriateness of treatment without trial	3.

Accepting 'good enough' Compliance

Need for choice (client) at all times	12.
May need to avoid compulsion to prevent hopelessness	12.
Balancing risk of compulsion with risk of non compliance	12.
Working 'well enough'	31.
'safe margin' of treatment flexibility	29.
Ongoing struggle with compliance	20.
Struggling with treatment; not the CTO	20.
Cost/ benefit analysis of treatment compliance	11.
Correlation between compulsion and hopelessness increases risk	11.
Suicide resulting from restriction	11.
Risk of treatment as high as non treatment	11.
Risk of 'backing people into a corner'	10.
Careful thinking about use of CTO	6.

Empathy for the Client

Awareness of the impact of compulsory medication	19.
Psychological factors underlying client response to care	11.
Unjustifiable to recall based on OT/ Therapy disengagement	25.
Lack of insight fuels non-compliance	5.
Clients often choose not to attend statutory appeals	16.
High frequency of tribunals- not always helpful for client	17.

Negotiating Boundaries

Chaos of psychosis indicates need for boundaries	10.
Boundaries helpful and also unhelpful	10.
CTO most effective when purpose clear	10.
Ethical duty to negotiate and discuss	5.
Importance of clearly defined purpose set amongst negotiation	8.
Imaginative treatment approach	4.
Practical need to discuss and agree	6.

Sharing the Process

Misconception that medic is at the top	13.
Ethos of shared responsibility	13.
Shared decision; shared risk	13.
Whole team discussion	14.

around decision making	
Team opinion sometimes mixed	14.
Use of informal discussion pre-renewal	15.
Multidisciplinary approach as essential	28.

Client Attitude to Medication

Irreconcilable perspectives (RC and client)	19.
Unpleasant side effects	5.
Clients suggested CTO	2.
Medication is only one part	9.
Client wanted medication anyway	7.

Repetitive circular conversations with clients	19.

SAM

Importance of Client Choice

AOT offers an alternative path	10.
Client *need*s options	10.
Offering control to clients	11.
Client freedom to take drugs/ get drunk	29.
Clients chooses CTO	7.

Adjusting to the Process

Acknowledging the change in practice	22.
Improved understanding of CTO	19.
Role of reflective practice	22.
Supervision	22.
Practical implications for job role- 'visit attempt number'	24.
Practical implications- 'weekend paperwork'	24.
Role of handover in collaboration	26.
Definition difficulties	28.
Inadequacy of CTO alone (stuck)	11.
Confusion over language	11.

Justifying Use of CTO

CTOs make job easier	5.
Organisation of chaos	7.
Illness damaged social interactions	7.
Long term process	12.
Effects of developing insight	7.
Principles of safe, sound and supportive care	28.
Belief in the process	12.
Potential to end long term patterns	6.
Hope that client will soon understand	6.
Duty to use as a last resort	7.
CTO as positive	32.
CTO fits AOT model	33.
Positive experience of tribunal	31.
Confidence in CTO	31.
Hope for positive impact on travel	12.
Universally communicable treatment approach	13.
Offers reassurance to others that someone's monitored	13.
Regulation of control	15.

Medical Model

Increased pressure of clozaril	27.
Discussion around injection dominates	8.
Creates focus on medication	11.
Concordance work	10.

Relationship and Engagement

Damage limitation- managing relationships around tribunal	31.
Engaging imaginatively- fitting around clients	11.
Focus on relationship	9.
Team flexibility	9.
Risk of preventing honest discourse with clients	27.
Flexible working required	22.
Difference of AOT	15.
Involvement of carers	12.
Potential difficulties in a CMHT	18.

Measuring Success

Hard to source root of improvements	13.
Uncertainty around when to stop CTO	14.
Emphasis on proving need for CTO	14.
Need for preparation around ending	28.
Need to evidence use of CTO	30.
Hard to measure success	15.
Solution focussed	25.

Variation in Clients' Responses

Impact of stage of illness upon attitude to CTO	9.
Age effects of response: labile vs. Burnt out	9.
Strong preconceptions of clients based on services	15.
Low coping threshold of institutionalised client	16.

Peer Support

Increase in (peer) supervision	20.
Role of peer support in managing difficult feelings	20.
Increased openness in team	20.
Importance of sharing out medication visits	24.
Team connectedness	25.
Use of routine team discussion	25.
Sharing difficult visits	20.
Sharing responsibility creates safer practice	32.

Managing Difficult Feelings

Staff self-doubt	19.
Impact on team overlooked	19.
Team guilt	10.
Impact on staff	8.
Staff stress	1.
Trying not to get stressed	20.
Staff stress of engaging	6.
Consultant finds it hard to recall	23.

Experiences of 'System'

System nurtures avoidance in staff	21.
Pressure to do more for less	21.
Impact on staff of changes in the trust	21.
Bullying culture of NHS	21.

Feeling Overlooked

Staff feeling uninformed	17.
Discrepancy in training across disciplines	17.
Training lacked transferability to clinical practice	18.
Nursing staff as vulnerable and undervalued	18.
Nurses on the 'frontline'- representing CTO	18.

In Conflict with the Medical Model

"I'm not my own"- challenge of self	8.
Representation of client, trust and self	30.
Influence of personal agenda	30.
Mismatch between principles and job role	30.
Stress of inner conflict	26.
Ideological opposition	26.
Impact of personal ideology on clinical practice	28.
Personal reluctance to enforce CTO	23.
Role as human, nurse, professional	9.
Personal stance at work	2.
Does it sit with me?	19.
Describing past experience of baselining clients	14.

Negative Aspects of Compulsion

Enforcement undermines engagement	1.
Legislation prevents trust	2.
Trauma of past hospital admissions	2.
Initial negative perception of CTO	3.
Fear of staff-centred implementation	3.
Locked doors on wards	3.
Compulsion used to replace resources	4.
Inpatient – anger at being 'penned in'	4.
Describing negative experiences of compulsion	4.
Fear of excessive use	5.
Experience of new powers being used too readily	5.
Destructive force of external control	8.
Recent suicide	10.
Impact on employment	13.
Potential for discrimination	13.
Powerful legislation	16.
Initial staff reluctance- CTO as complex	17.
Hard to end a CTO	16.
Risk of use to save beds	29.
Risk of use to ensure engagement	28.
Restriction and control	12.
Enforcement generates resistance	8.
Issue of mental capacity?	30.
Paternalism	30.

Law & Illness

CTO as prison sentence	8.

‘criminal sentence’	16.
Client feeling punished	10.
Language of law	10.